

Medical Times

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War-Time Gunshot Wounds*

R. HAMILTON FOWLER, M.D., F.A.C.S.,

Montclair, N. J.

FORMERLY MAJOR M. C., U. S. A., CHIEF OF OPERATING STAFF AND ASSISTANT CHIEF OF THE SURGICAL SERVICE U. S. A.,
B. H. 61, A. E. F.

Base Hospital 61, A. E. F., landed at Brest, France, on September 3, 1918, and proceeded to the rest camp at Pontanazen Barracks, formerly occupied by Napoleon's troops. We remained there one week when we were ordered to a large hospital centre at Beaune, Côte D'or, Advanced Section. Our troop train arrived at its destination after three days' travel. We were well satisfied with the buildings, which had been especially constructed and considered ourselves fortunate in receiving the assignment. Bare hospital buildings, however complete from the engineers' standpoint are not complete from the standpoint of a hospital unit. Hence a great task confronted us in getting our organization ready to receive patients.

The surgical staff was organized under one chief and an assistant to the chief. There were seven subsection or department chiefs, presiding over orthopedics, urology, the eye, ear, nose and throat, dentistry and roentgenology.

On September 30, 1918, we reported ready to function. There were 1,000 empty beds. We had no surgical dressings and but few surgical instruments. A drum sterilizer was borrowed from Base Hospital 47, which was then in operation, and had received its first patients about four weeks previously. Soon a large quantity of adequate, sterile dressings were prepared.

The first hospital train, or what we termed colloquially "a convoy," arrived about 8:30 on the evening of October 5, with 404 patients, the second at 12:30 A. M., October 6, with 232 cases. Six hundred thirty-six patients were received between darkness and daylight that same night, of these cases 438 were surgical. On October 9, we received another "convoy" of 145 cases. The

morning report of October 10, showed the ten general surgical wards of 50 beds each, 500 in all, contained but three empty beds, with 22 patients in the genito-urinary and 32 in the eye, ear, nose and throat ward, making a total of 551 surgical cases. We had thus more than half filled our hospital with surgical cases during the first four days of our operation. This was no small undertaking even for a large, well equipped and organized civil institution with a highly trained staff of men accustomed to work with each other and with every facility at hand. Our nurses had not arrived on the scene and we worked under the further disadvantage of not knowing the practical professional qualifications of our staff.

Our twelve crises expansion tents were then added, consisting of fifty beds each. These were placed back of the wards. Our capacity was thus increased to 1,600 beds. On October 13 we received our fourth "convoy." About two "convoy's" arrived weekly, until on October 31, 1918, we reached the high mark of 1,400 patients with 1,145 surgical cases.

We received in all 18 "convoy's," the last December 11, 1918, which brought us to a total of 2,403 admissions up to that time; of these 1,513 were surgical. There were about 400 additional cases admitted from other sources than hospital trains, making a grand total of 2,809 admissions, of these 58 per cent were surgical.

From this time on the number of cases gradually diminished, convalescents were sent to the convalescent camp and those wounded too severely to again become combatant soldiers, but who had recovered sufficiently to travel, were sent back to the United States.

On November 11, the day the Armistice was signed, we had a total of 1,346 cases, 1,071 of which were surgical. One month later there were 734 patients, more than half of which were surgical.

* Published by courtesy of the Surgeon General's Office, Washington, D. C.

There was little variation from this number until January 10, 1919, when the census fell to 591 cases. One week later this dropped to less than a hundred cases (55 surgical, only 6 of which were still unable to travel).

On October 7, 1918, the day after our first "convoy" arrived Base Hospital 47 loaned us two nurses for our operating room, and they remained with us until our own nurses arrived October 15. During these nine days, 55 operations were performed and dressings prepared and sterilized for a large number of wounded. Too much cannot be said in praise of the untiring work of our ward surgeons and corps men during this time.

The corps men, who had been drafted into the Army but two or three months previously from every walk of life and who were for the most part untrained as operating-room orderlies and ward attendants, were working night and day in the operating room and nursing in the wards as well.

The largest number of wounds due to projectiles were caused by shell fragments (65.14 per cent), machine gun (29.9 per cent), and rifle bullet wounds (2.67 per cent) came next in frequency. Grenades caused very few (2.02 per cent) while bayonet wounds were extremely rare (.18 per cent). A small percentage of wounds were caused by falling objects, stones, boards or trees. There were a few crushing injuries caused by some form of machinery, artillery or auto trucks.

Many of our cases received at our base had already been operated upon and most of these wounds, although they showed that they had been cared for in an excellent manner, were infected. We at once began a war on pus organisms with the aid of the Carrel-Dakin treatment. This was no small task, but untiring efforts to keep wounds clean and patients warm and well fed, soon showed effect by the rapid convalescence of the patients.

After the first two or three "convos" had been received we frequently found empty bed space so limited that all of the surgical cases from a fresh "convoy" would have to be placed in two or three wards. This of necessity threw the burden of work upon two or three ward surgeons and caused some delay in affecting an early change of dressings and bacteriological examinations to determine the type of infection.

Up to this time all patients had passed from the receiving ward into the bath-room where every patient, regardless of how sick or how severely wounded, was given a bath (shower or scrub on the table as seemed indicated) and examined for cooties. They were then transferred to the ward designated. There the ward surgeon redressed every wound and took smears and cultures for bacteriological examination. Hot coffee and broth were then served and the patient made as comfortable as his wounds would permit. This often necessitated the ward surgeon working all night and many times well into the next day before his work could be completed.

To overcome this difficulty we established what we believe to have been original in our Centre with Base Hospital 61, namely a dressing station in the operating pavilion, where all newly admitted surgical patients were taken directly from the bath-room. Here a corps of surgeons and nurses under supervision of the writer redressed and examined every wound, while the pathologist and his laboratory assistants made smears and cultures from every wound. The patient was then sent to the designated ward where he received his hot coffee and broth.

This system had many advantages, the most important of which was the saving of time in the dressing of

wounds. It also facilitated early bacteriological reports. Aside from the time saved, many conditions requiring operative interference was thus detected immediately upon admission and if urgent, were operated upon at once or scheduled for the next day. Splints were re-adjusted here, and where any doubt existed as to the proper reduction of fractures an immediate x-ray examination was made.

The early bacteriologic reports thus obtained were of great value, especially in cases in which gas gangrene-producing bacteria were found. Those cases were watched closely and upon the first clinical symptom of gas infection a wide excision was made of the muscles and fascia. Many cases were given the benefit of anti-gas gangrene serum. When these measures failed to stop the progress of the disease, an amputation was performed which in most cases saved the patient's life.

Our results in blood transfusion were excellent. Early in the period of our hospital life, our corps men had been grouped for use as donors and we were never short of volunteers. When blood was needed for wounded German prisoners, of whom there were quite a number, convalescent Germans were grouped and blood taken from them to supply the needs of their comrades. We used transfusion with very gratifying results in badly exanguinated and shocked cases, frequently as a preliminary to amputation or other operation. We employed the citrated blood method.

Five hundred and fifty-five cases were operated upon during the period from October 7, 1918 to January 26, 1919:

Amputations	47
Arm, Upper	4
Forearm	2
Finger	1
Thigh	25
Leg	10
Foot	3
Toes	2
Appendectomies	14
Application of Plaster Casts	15
Arthrotomies	3
Bone Repair	4
Breaking Up of Ankylosis	5
Dacrocystitis	1
Enucleation of Eye	1
Hemorrhoidectomies	18
Herniotomies	21
Hydrocele	33
Incision and Drainage	144
Ligation of Arteries	5
Mastoid	2
Operation on Nose	5
Removal of Foreign Bodies and Wires from Jaw	2
Paracentesis	4
Phlebotomies	7
Plastic Repair	19
Revision of Stumps	15
Arm	1
Finger	4
Thigh	8
Leg	2
Removal of Foreign Bodies	48
Removal of Ingrowing Toe Nails	3
Resection of Joints	7
Ankle	2
Knee	2
Hip	3
Removal of Polypoid Tumor, Naso-pharynx	1
Secondary Closures	113
Sequestrectomies	13
Skin Graft	8
Tendonorrhaphies	2
Thoracotomies	5
Tonsillectomies	7
Transfusions	7
Transplantation of Pterygium	1
Total	555

There is a record of 108 foreign body cases. About 80 per cent were shell fragments, 11 per cent were machine-gun or rifle bullets, 3 per cent were in-driven spicules of bone and 1 per cent were pieces of clothing.

The operating pavilion was very completely equipped. A satisfactory steam heating plant was installed in November. The operative work in general might be divided into three phases: The first covered the first five or six weeks and consisted chiefly in wound excision and the removal of foreign bodies. The second phase extended up to Christmas and consisted in the main of secondary closures. The third phase extended from this time to January 31, 1919, and consisted in the operative treatment of compound fractures.

All anesthetics were given by the corps men. These men before coming into the Army had for the most part never given an anesthetic; yet under the tutelage and the supervision of the operating room surgeons, they soon gained the required skill and knowledge. There were 422 etherizations. Chloroform was administered but five times. There were 89 operations performed under local anesthesia. An average of 110 cases were dressed a day in the dressing room in the clinical building established for convalescent patients able to be up and about.

In our studies of classified gun-shot wounds as a whole we found that the largest number of gun-shot wounds involved the lower extremity, the greater number the thigh and leg. The next region, in order of frequency, was the upper extremity, of which the greater number involved the forearm and upper arm. The thorax was involved to the extent of about 8 per cent, as was the abdominal region. In about 5 per cent the nervous system was wounded and in the same percentage the facial region. We find about 5 per cent of wounds of the pelvic region and about 5 per cent of wounds of the shoulder girdle, 3 per cent of wounds of the head, and 1 per cent of wounds of the neck.

There were 43 deaths in the surgical service, a mortality of 2.6 per cent. Four died following operation in our own hospital an operative mortality of seven-tenths of 1 per cent.

Of the 43 deaths in the surgical service 12 had been previously amputated elsewhere; in 22 others an operation of some kind had been performed. There were 7 deaths in which no operation was performed and in 2 no statement can be made with regard to operation or otherwise, on account of incomplete Field cards. A comparison of the clinical and post-mortem diagnoses was made the subject of critical analysis and furnished interesting information.

Analysis of Fatal Cases

A study of the post-mortem diagnoses shows 47 chest complications. Forty cases showed the lungs and pleura involved. Seven involved the heart and pericardium. In the series of forty lung and pleura conditions there were eleven cases of broncho-pneumonia. There were seven cases of empyema. There were also seven cases of acute or chronic fibrinous adhesive pleurisy. In six other cases the type of acute pleurisy was not stated. There were three cases of pleurisy with effusion. There were two cases of pulmonary tuberculosis. Two cases of hemothorax were recognized. In one case, bronchitis was unrecognized clinically. In one case bronchitis was mistaken clinically for tuberculosis. One case of pulmonary embolism was not recognized.

There were seven complications of the heart and pericardium. There was one dilatation and hypertrophy of the heart. There were two cases of pericarditis and

three cases of endocarditis. There was one congenital fusion of the aortic valve flaps.

In the post-mortem series there were five penetrating wounds of the chest. In one case a traumatic diaphragmatic hernia of the colon existed.

A study of 14 cases of gas-gangrene shows that four were apparently not recognized. (These were among the worst cases with which we had to deal.) There were nine cases of nephritis, acute or chronic.

There were six abdominal lesions. They all involved intra-abdominal structures. Four were penetrating gun-shot wounds. In one case the missile entered the abdomen through the chest, one case was a non-penetrating gun-shot wound of the abdominal wall and in this case the peritoneum was invaded by contiguity as was another to be related later. There were five cases of peritonitis; four were diffuse and one was localized. There was one injury to the liver and one penetration to the colon. The former was unaccompanied with peritonitis, was slight, was not recognized clinically and not considered the cause of death. There was one post-operative death among these which deserves special mention. The case was one of empyema of the appendix—acute suppurative appendicitis, localized within the organ (as was shown when the organ was split later). The organ was removed without rupture and the incision closed without drainage. The immediate post-operative reaction the same night was 103° F. Chest examinations were repeatedly negative. The patient looked very sick. This persisted until the second day when the wound was examined and the right iliac region in the vicinity of the McBurney incision was found to be marked by red, swollen, and edematous. The sutures were removed at once and the wound separated down to the peritoneum. A small amount of thin, yellow, clear liquid and some gas bubbles were expressed from beneath the aponeurosis of the external oblique. The wound was laid wide open and drained with tubes placed between the fascial planes and down to the peritoneum. The next day the temperature dropped somewhat. Anti-gas serum was administered and on the fourth evening the temperature dropped below normal. The condition of the abdominal wound remained *in statu quo*. Bubbles and a thin serous discharge continued. The following day the patient died. Unfortunately there is no record of the bacteriologic examination, though cultures were taken, but the writer is certain the infection was due to gas forming organisms, probably the B. Edematis. The edema was very extensive. It extended to the lower ribs above, down over the right groin and to the midline of the abdomen. Section of the muscles at autopsy was attended with characteristic gritting. The infection had spread for the most part between the oblique muscles but beneath the skin as well to a less extent. The peritonitis showed itself for the most in adherent loops of gut, injection of the intestinal visceral peritoneum and in a small amount of serous fluid.

We were unable to trace the source of the infection, though cultures were made in the operating-room from gloves, instruments, dressings, gut, etc.

There were two instances of septic infarcts of the spleen and two cases of splenitis.

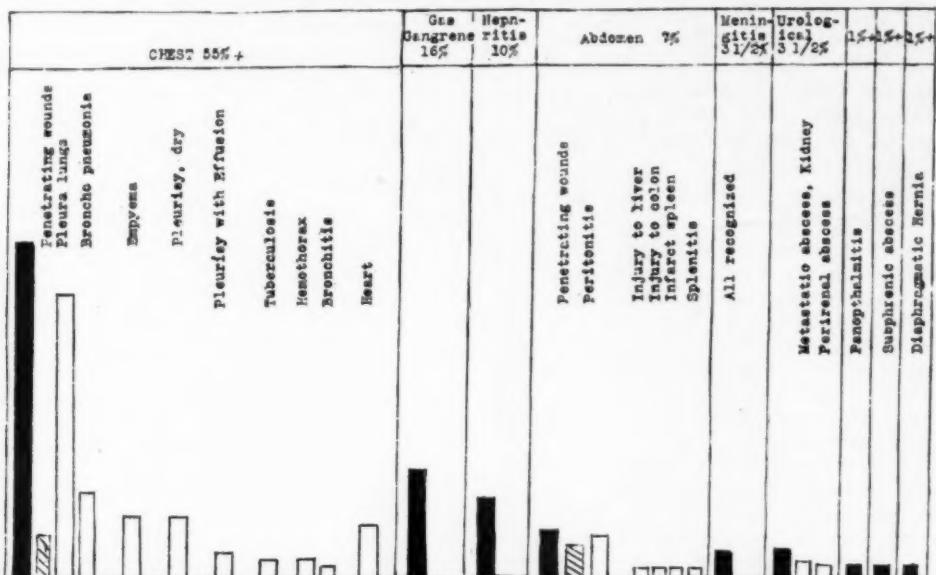
There were three cases of meningitis. There were two instances of metastatic abscesses in the kidneys and one perirenal abscess. A case of brain abscess was correctly diagnosed clinically. There was one case each, of panophthalmitis, subphrenic abscess and diaphragmatic hernia.

On the morning of January 31, 1919, a telegram was received from the Chief Surgeon's office, A. E. F., which stated that Base Hospital 61 was to be returned to the United States. Before midnight the same day we had

evacuated 79 remaining patients to another base in the centre, disposed of our equipment, closed our records and ceased to function as a hospital.

In reviewing the cases of gun-shot wounds of the abdomen these were found to be comparatively few. (6.80 per cent.) In order to account for this percentage we

THE COMPLICATIONS IN 43 FATAL CASES.



Group studies made by the writer of gun-shot wounds of the chest, and cranio-cerebral wounds due to projectiles, etc., which occurred in our organization, have appeared elsewhere.

must consider that such wounds were in many cases fatal from hemorrhage before treatment could be given and again that many died in front line dressing stations and field or evacuation hospitals.



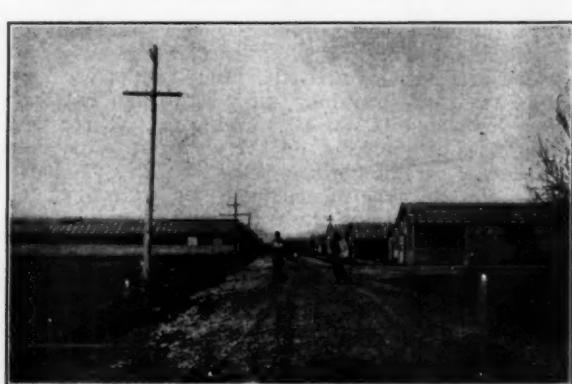
Headquarters Base Hospital 61, Beaune Hospital Centre.



Pathological Laboratory Building, B. H. 61, A. E. F.



Surgical Team dressing newly arrived patients in the operating pavilion, B. H. 61, A. E. F.



Receiving Ward in the foreground. Rows of Surgical Wards, B. H. 61, A. E. F.

The average length of time that elapsed from the time these cases were treated at a dressing station until they arrived at this base was five days. The average length of time that they were kept at this base was 45.6 days.

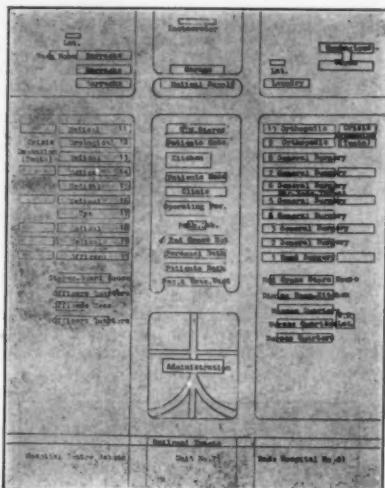


Chart showing arrangement of a typical unit provided for each base hospital at Beaune.

Of the 115 cases there were 97 of the abdominal wall and 18 involving the peritoneum and viscera. The number of deaths was about 5 per cent. The wounds were caused by machine-gun bullets, high explosive fragments, hand grenades and bayonets. All wounds were infected. Two interesting autopsy protocols are presented herewith:

Case 1.—Pvt. D. J. B., No. 1597136. Wounded October 10, 1918. Died October 30, 1918. Admitted B. H. 61, October 28, 1918. The diagnosis on the field card was gunshot wound of the abdomen, involving the external oblique and transversalis muscles. Pleurisy, bilateral, with effusion. Peritonitis was recognized on admission. The post-mortem anatomical diagnosis was acute peritonitis and acute fibrinous pleurisy. On examination after death it was found that the floor of the wounds consisted only of the peritoneum. On opening the abdominal cavity the parietal peritoneum was found thickened and covered with a

The liver was found normal in size. The lower surface and anterior border were covered with a fibrinous exudate. The lobules were surrounded by a yellowish ring due to fatty infiltration. The spleen was covered with a plastic exudate. Bacteriologic examination of the heart's blood, fluid from the abdominal cavity and pleura showed streptococci.

Case II.—Sgt. G. J., No. 2267259. Wounded October 16, 1918. Died November 8, 1918. Admitted B. H. 61, November 7, 1918. Diagnosis on field card, gunshot wound, right thigh. The wound of entrance was just below Poupart's ligament. Post-mortem anatomical diagnosis was: diaphragmatic abscess, peritonitis and broncho-pneumonia. At autopsy examination of the abdomen revealed the following conditions: Intestines were covered with exudate. Pus in the right iliac fossa. Communicating wound from a point just below Poupart's ligament to peritoneal cavity. A rough piece of shell jacket was found in the right iliac fossa. Firm adhesions were found between the small intestines and there was a tangled adherent mass of intestines 8 feet from the pylorus which had caused a distinct obstruction. Examination of the respiratory system disclosed the usual findings of broncho-pneumonia, also the following conditions: firm adhesions at different areas between the lobes of both lungs, pus in the bronchi of the lower lobes of both lungs with adjacent pleura adherent to diaphragm. Examination of the urinary system showed the left kidney congested with a scar leading to a cyst-like cavity. This scar and the cyst-like cavity had the appearance of an old lesion. The liver was slightly enlarged and covered with a fibrinous exudate. Examination of the contents of the skull showed a small amount of pus in the ethmoid sinus. Upon bacteriologic



Main operating room, Base Hospital 61, Beaune Centre.

examination the peritoneal fluid was found to contain streptococci and *B. coli*; the lungs streptococci, staphylococci and a gram negative bacillus in long filaments, unidentified. A smear from the ethmoid sinus showed a gram positive diplococcus.



Hospital Train on the Siding. Beaune Hospital Centre.

fibrinous exudate. This exudate was also found on the rectum, colon and lower part of the ileum. The abdominal cavity contained about 150 cc. of turbid fluid. There were many adhesions between the intestines, all of which were easily broken up. The right pleural cavity contained about 500 cc. and the left 300 cc. of turbid fluid. Both lungs were found adherent to the pleura.

Comments

At the commencement of the World War there were two opinions current with respect to the treatment of wounds of the abdominal viscera. One school held that expectant treatment was the proper procedure, mainly because it had been accepted as orthodox because of the high mortality attending operation. The other school was stoical in that it believed that expectant treatment was the best treatment that could be given under the circumstances of war. It soon became evident, however, that emergency abdominal operations to be successful must be done at once and it was obvious that to wait until a later period was to court disaster. To operate at the front with a retreating battle line is not possible and all that can be done is to return the wounded to the base with as little discomfort as possible. But when the line becomes a fixed one, conditions are very different. The problem is then changed and it no longer becomes a question as to whether these patients *could* be operated upon but whether they *should* be operated upon. Early in the war the effort was directed toward avoiding as much dis-

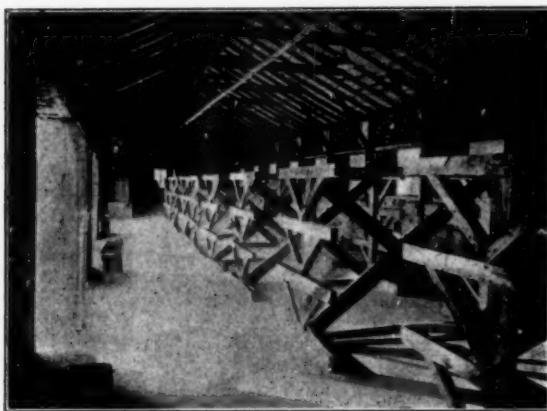
turbance of movement as possible. The wounded soldier was kept near the front line, given warmth and rest, put in the Fowler position, food and drink was withheld, morphine and rectal salines were administered and frequent mouth washes given to overcome dehydration.



Crisis Expansion Tents back of the wards of B. H. 61.

Despite the prevailing opinions fostered by the experiences of the Boer and other wars, even early in 1914, attempts were made to treat these cases by early operation. Thus Souttar, working with the Belgians, commenced his work in September of that year. Captain Owen Richards was the first to publish his results of operative treatment in the British Army. His first operation was performed January 28, 1915, and his first successful case—an excision of $2\frac{1}{2}$ feet of small intestine was performed on March 18, 1915, thirty-six hours after injury. By this time operations and post mortem examinations revealed that success was not to be obtained without surgical aid except in a few instances.

In spite of the fact that the immediate mortality in these cases is due to hemorrhage, advocates of the expectant treatment seemed to have rather blindly focussed attention more on the danger of peritonitis. Re-establishment of the fact that the chief cause of early death was hemorrhage caused these cases to be sent with celerity to the nearest station for operation at once. Results showed an immediate improvement. After the battle of Loos, the British opened special advanced hospitals for



Litter racks. Receiving Ward, B. H. 61, A. E. F.

abdominal and thoracic cases. The number of abdominal wounds which reached an advanced operating centre, provided there was no segregation, averaged about 2 per cent of the total wounded received. The sorting of these cases for operation imposed a great responsibility. In

general those excluded from operation were: 1. Moribund cases (20 per cent). 2. Certain wounds due to small metal fragments and bullet wounds of the liver. 3. Cases arriving at the centre late, more than 24 hours after receipt of injury, also frequently not desirable cases for operation.

Case I, cited above though a wound of the parietes without visceral injury, is german to the subject and forms the text in making a few additional points. This case, in the absence of other more urgent emergencies would no doubt have been explored and given a more thorough treatment. In general terms, when there is doubt it is best to explore. An instance of this character is the following case seen a number of years ago in civil practice:

H. M., age 10, school boy, was admitted to the Kings County Hospital, Brooklyn, N. Y., November 1, 1914.

Present illness: The child was picking mushrooms in an open field in the outlying district of the Flatbush section when he received a bullet wound in the left side of the abdomen at nine o'clock of day of admission from some unknown source from behind. He was taken to the Relief Hospital and then trans-



H. M.—Kings County Hospital Case. Gunshot wound of the abdominal wall.

ferred to the Kings County. He experienced a stinging pain. The wound did not bother him, but there was some discomfort on coughing and on taking long breaths; no vomiting.

Physical examination revealed a fairly well developed and nourished male child of ten years, skin and mucous membranes of good color. He did not appear acutely ill. No shock present. The patient lay in bed with the left thigh and knee flexed. Pupils were equal and reacted to light and accommodation. Tongue slightly coated, teeth in good condition. Tonsils slightly prominent, cervical and axillary glands palpable.

Heart and lungs normal.

The abdomen was not distended, the left upper quadrant was held somewhat tense. Complete relaxation could, however, be obtained. No tenderness or masses.

With the patient upon the right side careful inspection showed the posterior wound of entrance to be on a slightly lower level than the anterior (see illustration). The wound of exit corresponded with a line drawn upwards from the anterior superior spine of the ileum, being two and three-quarter inches above this point. The wound of entrance was equally distant from the iliac crest, and the tip of the 12th rib. It was three inches from the mid spinal line. There was some swelling in the region traversed by the bullet.

Laboratory reports: W. B. C. 25,000. Polys 80. Large lymph 5. Small lymph 13, trans. 1, Eosin 1. Urine normal.

Preoperative diagnosis: Gunshot wound of the abdominal wall (without injury of the abdominal viscera). Exploration advised to make assurance doubly sure.

(Concluded on page 129)

A Case of Suppurative Pyelitis: Nephrectomy, Cure*

Death Later from Pyelonephritis of Opposite Kidney

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The following example of acute suppurative pyelonephritis with temporary cure by nephrectomy, is worth reporting on the grounds that the patient had passed from clinic to clinic without a cystoscopy or other competent urological diagnosis and that the various elements of the final examination were singularly consistent and complete as indicating the necessity of operation without delay. The former situation is peculiar in that the clinics were those of hospitals well known throughout the country, in one or more of which, however, cystoscopic examination are not permitted in the outpatient department, a restriction which in this day and generation is almost scientific ignorance.

History.—J. C.; case No. 56280; U. S. A.; admitted August 26, 1914. Chief complaint pain in the left side of upper abdomen, loss of weight, weakness, fever and chills. Family history states that father died of the age of sixty-six of chronic bronchitis, mother at fifty-five of paralytic stroke. Has two sisters and one brother living and well. There is no history of nephritis, diabetes, rheumatism, cancer, heart disease, or tuberculosis. Previous personal history states measles at six years (evidently without renal sequels), medical negative, surgical negative, venereal includes gonorrhea ten years ago with treatment for one year. A chancre (?) was present at the same time. He has had three blood tests taken, all negative. Habits include two cups of coffee, one cup of tea a day, no alcohol, good appetite, irregular bowels. Must take cathartics about twice a week. Marital history covers five years. Wife has had no pregnancies or miscarriages. (No statement is obtainable as to whether this is intentional or incidental).

Present complaint dates back about seven years when patient had severe pains on the left side of upper abdomen. He applied a porous plaster which is claimed to have brought out eczema of face, arms and legs lasting two weeks. From then until July 21, 1914, he has never had pain in the abdomen on the left side. On that day he was away in the country, playing hand ball, became much heated, perspired freely and lay down on the grass to cool off when he was seized with severe pain in the upper abdomen on the left side. He then went into the house and remained in bed that day, but could not lie on that side. The pains were continuous that day and the next day, when a physician was called and diagnosed malaria. He then got out of bed. The pains continued for two weeks during which he was in the country. He was not able to sleep at night. With the onset of pain about eight o'clock each evening, he was seized with a severe chill, accompanied by chattering of the teeth for a few moments and followed by a fever lasting about fifteen minutes and then by apparently normal condition. While in the country he did not lose weight. During these two weeks he vomited twice. He passed water more often than usual, cloudy and containing shreds. From the country he went immediately to his city physician who diagnosed left pleuropneumonia. He then went directly to bed at home but was without pain in the chest but always had a slight cough. A negative Widal reaction was obtained. His temperature now went up to 104° and so remained for nearly a week and he was

getting weaker from day to day. A Brooklyn physician diagnosed ptomaine poisoning. Then he lost weight rapidly up to 22 pounds in three weeks. At this time he did not have chills and fever at night and the urine was still cloudy. Appetite was poor. When he entered the hospital he still had the pain on his left side which had been continuous since the beginning of his sickness on July 21st.

Physical examination. Heart and lungs apparently normal. A well-built working man obviously very sick and septic. In the left hypochondrium and left lumbar regions was a dense, tense, somewhat tender mass not corresponding with the spleen but rather definitely with the kidney. Laboratory examination. Blood counts showed total white cells 16800, polys 82%, lymphocytes 15%, mononuclears 2%. Urinalysis on admission showed a casual specimen 1012, acid, light amber, cloudy with pus, marked amount of albumin, no sugar, no blood, no casts, no red blood cells but large numbers of pus cells. No bacteriology of the urine was done but from the odor of the pus at the time of the operation there is no doubt that the *bacillus coli communis* was at least one of the infecting organisms. Urologic examination. Revealed normal penis, testicles, urethra and prostate. The bladder washed readily and rapidly clean of pus and revealed a comparatively normal mucous membrane without definite suggestion of tuberculosis. The right ureter was normal except that it was discharging urine not altogether healthy. The left ureter was prominent, enlarged, thickened, inactive, except that strings of mucus and pus seemed to be gravitating from it. There was absolutely no functional discharge of urine. Ureteral catheterization was decided on and performed August 26, 1914, with size 5 Fr. catheters on each side. On the right the instrument passed very readily for 15 centimeters and immediately began to drain away a rather large quantity of slightly turbid urine, about 30 c.c.s. in 15 minutes. Analysis of this specimen showed normal specific gravity and percentage of urea, a trace of albumin, no sugar, numerous pus cells and an assortment of casts including a few epithelial and pus casts and red blood cells. Specific gravity was not taken. Reaction acid. On the left side the catheter could be engaged hardly beyond the eyes of the tip and delivered no urine whatever, when withdrawn into the field of the cystoscope slugs and strings of mucopus were attached to it. In fifteen minutes no urine came from this side through or around the catheter and there appeared to be leakage around the right catheter into the bladder. The phenosulphonephthalein was next undertaken intravenously. A cubic centimeter syringe was carefully filled with the dye and the same syringe was employed as the measure of the cubic centimeter of the dye in making up the standard solution and in thus securing as nearly as possible absolute comparison for the percentage of excretion. In 15 minutes, 15 c.c.s. of 1010 specific gravity containing 35% of the dye were excreted by the right kidney through the catheter and in the bladder leakage which totaled 200 c. cs. with 1012 S.G. were 17% more of the dye. From the left side of the dye, however, not one drop of urine or dye was delivered. Much of the bladder contents was dilatation fluid which was not re-

(Concluded on page 129)

* From the Surgical & Urological Services of St. Mark's Hospital.

Halle's Clinic Halle's Intranasal Sinus Operations Ozena and Lacrimal Sac Operations*

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When visiting Dr. Halle's clinic in Berlin, one cannot help but become profoundly impressed and even enthused with the display of technical skill, inexhaustible amount of vitality and great learning of the master technician and his associates. Dr. Halle's dexterity, vitality, firmness, precision and skill have no bounds or limitations. He operates, demonstrates, lectures and treats patients from early in the morning until late in the afternoon, without showing the slightest degree of fatigue. With a group of men gathered about him from all corners of the world, he passes from room to room demonstrating with an unbelievable degree of dexterity and speed, the most difficult and intricate intranasal operations, plastic and cosmetic surgery of the head and neck. He may be seen performing at one sitting, a septum, double ethmoid, sphenoid and double frontal sinus operations, on a patient fearful but made confident by the masters commanding bearing and voice, as tame as a lamb, never uttering a word of complaint. A moment later we find him performing a radical mastoid and completing the operation with his electric burr. In the next room a few minutes later we see him employing the old and almost obsolete tonsillatome in sludgering out a pair of tonsils. The procession moves ahead and we witness a remarkable demonstration of an esophagoscopy and bronchoscopy. This is followed a few minutes later by correction of a saddlenose deformity with an elephant-bone implant, and before the noon hour has been reached we see him demonstrating his unique and very technical intranasal lacrimal sac operation.

In the afternoon at his polyclinic we again find Dr. Halle hard at work. Here he demonstrates in great detail with wet specimen and in cross sections all the steps of his intranasal operations. The technique of operations such as the radical ethmoid, front sinus, lacrimal sac and ozena, heretofore difficult to grasp or understand, are made clear and simple to all. Following a demonstration of this kind one feels that those of us who have had a training in rhinology may perform any of these operations without any hesitation.

To summarize these very interesting demonstrations, one may say the following: that with a thorough understanding of the anatomy of the head and neck, and most intelligent interpretation of the function of all intranasal structures as a background for his intranasal surgery, Dr. Halle strives for results which will not only give cures, but will leave all intranasal structures intact, and in as normal a state as may be possible. When one examines a case immediately after a radical ethmoid or frontal sinus operation has been performed, it is at times difficult to tell whether or not an operation has been performed, so little damage has been done to the nasal mucosa.

A good understanding and thorough knowledge of the anatomy of the head and neck is urged by Dr. Halle before one attempts the technique of his intranasal operations. A cadaver course is very justly required and given by his staff before one is permitted to operate on the living. The cadaver course given by two able associates, Drs. Engleman and Hamburger, is most interesting and instructive.

In the following paragraphs the writer wishes to describe briefly some of Dr. Halle's intranasal operations as he is doing them at the present time.

The Ozena Operation

It is thought adviseable in this communication not to go into a discussion of the merits or demerits of this operation insofar as curative results are concerned, but rather to point out the underlying principle and describe the technique of this unique and ingenious operation.

In performing this operation the rhinologist aims to bring about through mechanical means a narrowing in the very roomy and atrophic nasal fossae and thereby relieve the disagreeable symptoms of drying, crust formation and foul odor. To obtain this result, the inner wall of the antrum is brought up against the nasal septum and held there for a period of time until adhesions have been formed between the turbinate bones and corresponding surface of the nasal septum.

Technique of Radical Ethmoid Operation

(a) The entire outer nasal wall including the turbinates are anesthetized by rubbing it with a 10% solution of cocaine, then injected with a $\frac{1}{2}\%$ solution of novocaine adrenalized. The sphenopalatine gangleon and infraorbital region are then injected with the same solution.

(b) An L shaped incision is made in the nasal mucosa in the following manner. The vertical limb of the L beginning in front of the head of the middle turbinate and extending to the head of the inferior turbinate; the horizontal limb of the L continuing from the head of the inferior turbinate across the floor of the nose to the septum nasi. (Fig. 1).



Fig. 1. a—Vertical limb of L shaped incision. b—Horizontal limb of L shaped incision. (Ozena operation.)

(c) Through the horizontal incision made across the floor, the entire mucosa lining the floor is elevated, also elevating somewhat the mucosa of the inferior meatus.

(d) A long Killian speculum is then inserted between the mucosa and floor of the nose. We thus obtain a very good view of the lower anterior portion of the inner or nasal wall of the maxillary antrum.

(e) With a long thin chisel the antrum is entered at the floor of the nose anteriorly, and the entire lower border of the inner antrum wall chiseled from the floor. Following then the first line of incision, the anterior border of the inner antrum wall is penetrated, this time

* Read before the Beth Israel Hospital Alumni Association, November 23, 1922.

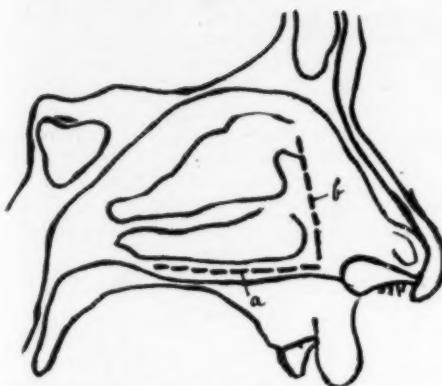


Fig. 2. a, b—Trap-door opening made into antrum with chisel.
(Ozena operation.)

chiseling through mucosa and bone. (Fig. 2). A trap-door-like opening into the antrum has thus been made, through which the entire cavity may be inspected and treated by introducing a Killian speculum and pushing the bony flop towards the nasal septum.

(f) The entire inner antrum wall is then gradually pushed over with a long blunt instrument and held tightly against the nasal septum by packing the antrum with iodoform gauze. In order to bring about a more rapid formation of adhesions, the turbinates and the nasal septum are refreshed on their corresponding surfaces.

Post Operative Treatment.—The antrum is repacked every succeeding six days for six times, until the adhesions between the turbinates and nasal septum have been formed and the antrum closed.

Technique

(a) The mucosa lining the entire nasal cavity is thoroughly anesthetized by rubbing it with a 10% cocaine solution adrenalized, and then injected with $\frac{1}{2}\%$ novocaine solution. The latter is also injected into the ethmoid cells and when doing a frontal sinus, the region of the supraorbital nerve is also injected.

(b) In this as well as in all other intranasal operations the middle turbinate is preserved. By means of a long blunt instrument or a long Killian speculum the inferior turbinate is pushed out of the way and tightly against the nasal septum. A very good view may then be obtained of the middle meatus. With the middle turbinate intact, injury to the cribriform plate or perforation into the anterior fossa of the cranium is practically impossible.

(c) With a good view of the ethmoidal region and every manipulation under direct control of vision, two



Fig. 3. a, b—Horizontal incisions into ethmoid labyrinth.
c, d, e—incisions for mucoperiosteal flap.
(Ethmoid operation.)

incisions are made into the ethmoidal cells. (Fig. 3). One incision right beneath and horizontal to the middle turbinate, the other incision about $\frac{1}{4}$ of an inch below and horizontal to the first. The latter passing through the uncinate process.

(d) The ethmoid cells are now opened into by punching out with a sharp punch forceps the cells included between the two incisions made into the ethmoid labyrinth. A small sharp curette is now used to clear away the debris and open other ethmoid cells now accessible.

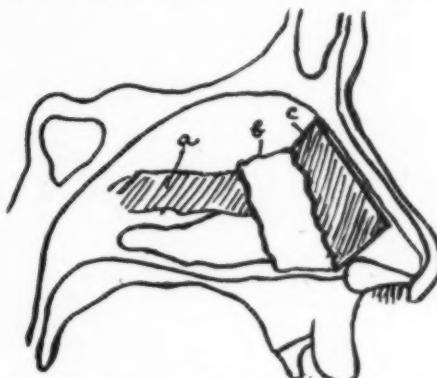


Fig. 4. a—Portion of ethmoid cells punched away.
b—Mucoperiosteal flap.
c—Bare bone surface caused by elevation of mucoperiosteal flap.
(Ethmoid operation.)

Continuing posteriorly the sphenoid sinus may be easily entered and explored.

(e) In order to expose the uppermost, anterior and preterbinal area of the ethmoid labyrinth, a mucoperiosteal flap is made in the following manner. (Fig. 3). Three incisions are made to complete this flap. 1. From the head of the middle turbinate running upward to the roof of the nose or internal border of the nasal bone. 2. From the upper border of incision one running along the outer wall of the nose and as near the roof of the nose as possible. 3. Begins from the end of incision two and carried along the inferior border of the nasal bone and extended

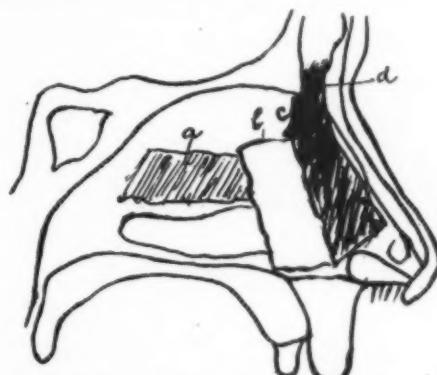


Fig. 5. d—Removal of agar nasi and floor of frontal sinus with chisel and electric burr, making a wide opening into the frontal sinus.
a, b, c—same as Fig. 4.
(Frontal sinus operation.)

down along the pyriform aperture to the level of the head of the inferior turbinate.

(f) The flap is elevated from the bone beginning anteriorly at the pyriform border and reflected downward upon the inferior turbinate. A very satisfactory view is so obtained of the upper and outer bony nasal wall, very frequently the seat of diseased anterior ethmoidal cells. (Fig. 4). With a small sharp curette these cells are completely cleared out and exenterated.

(g) When one has satisfied oneself that a thorough removal of all diseased parts has been accomplished, the flap is returned to its place and held there with a small



Fig. 6. a—Middle turbinate replaced. b—Mucoperiosteal flap replaced. c—Opening into the frontal sinus. (Frontal sinus operation.)

piece of iodoform gauze packing. The middle turbinate is pushed back in place and the operation completed. (Fig. 6). The packing is removed in 24 to 48 hours.

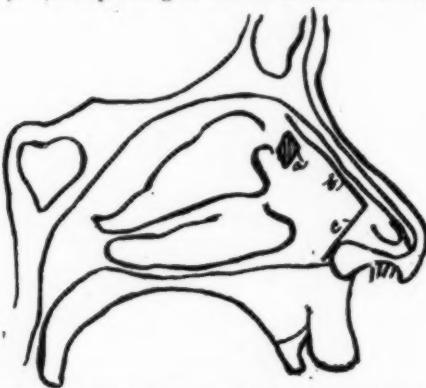


Fig. 7. a—Window of mucoperiosteum cut out over region of torus lacrimalis. b, c—Lines of incision for mucoperiosteal flap. (Lacrimal sac operation.)

The post operative treatment consists of nasal douches given daily.

Technique of Frontal Sinus Operation

(a) The field of operation is anesthetized as outlined above. The middle turbinate is pushed out of the way

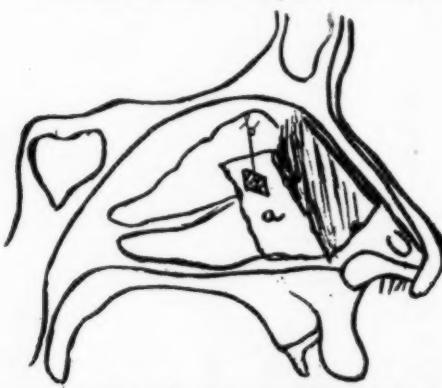


Fig. 8. a—Mucoperiosteal flap separated and reflected down across the inferior turbinate. b—Fenestrum in the flap. (Lacrimal sac operation.)

towards the nasal septum and the mucoperiosteal flap prepared in the same manner as for the ethmoid operation.

(b) The agar nasi is then reduced by chiseling it away. The electric burr is not used in this step of the operation. When the agar nasi has been properly reduced the opening into the frontal sinus will be seen very clearly.

(c) The latter opening is enlarged by removing the floor of the frontal sinus either with curettes or more preferably the pear-shaped electric burr. (Fig. 5). It is advisable to begin with the smallest size burr and gradually change to larger sizes. As every step is done under direct control of vision, there is very little danger in this procedure. The use of the electric burr is not



Fig. 9. a—Mucoperiosteal flap. b—Lacrimal sac exposed and resected. c—Quadrelateral section of bone cut out with chisel within the nasal bone to expose the lacrimal sac. d—Probe passing through canaliculus into lacrimal sac. (Lacrimal sac operation.)

at all essential in obtaining a good result, as a very good opening into the frontal sinus can be obtained by the proper use of the curved frontal sinus curettes.

(d) The mucosa lining the sinus can now be curetted by using the proper shaped frontal sinus curettes. Care



Fig. 10. a—Mucoperiosteal flap back in place. b—Fenestrum in flap for discharge of lacrimal secretion. (Lacrimal sac operation.)

must be taken to prevent injuring the medial and frontal sinus walls.

(e) The mucoperiosteal flap is replaced and held in position by iodoform gauze packing. The middle turbinate is restored to its original position. (Fig. 6).

Post operative treatment consists in the removal of the gauze packing on the second or third day and the frontal sinus irrigated through a cannula every day or so according to the condition present.

Technique of Lacrimal Sac Operation

(a) The entire outer nasal wall is anesthetized as above.

(b) A quadrelateral incision is made just in front of the head of the middle turbinate and over the torus lacrimalis.

(Concluded on page 130)

A Plea for Early Diagnosis of Tuberculosis of the Urogenital Tract*

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Probably no other urological condition escapes early recognition as often as tuberculous infection of the genitourinary tract. Renal or epididymal tuberculosis frequently give rise to no alarming symptoms, and, unless there is vesical involvement, to no severe urinary symptoms. When it is also remembered that tuberculosis of the urinary and genital organs is frequently associated with an apparent state of general well being and good health, it is understood how easily this condition may go unrecognized. We are well trained to the necessity of subjecting our patients, presenting symptoms of incipient pulmonary tuberculosis, to a thorough clinical and laboratory investigation. That has been drilled into our minds time and time again in the medical schools, by public health propaganda and in the current literature, but how often is a patient, presenting himself to the physician, perhaps with a dull ache in the costo-vertebral angle, perhaps with a slight increase of frequency on urination and a slight pyuria, subjected to similar investigation? When it is remembered that renal tuberculosis is primary in the urinary tract, and is unilateral in the early stages, and that with or without secondary invasion of the bladder the disease has a tendency to become bilateral, thus contraindicating surgical intervention, the importance of an early diagnosis may be well realized. The same may be said of genital tuberculosis, where the primary focus, the epididymis, is in the beginning involved unilaterally, and where an early epididymectomy may preclude the extension of the process into the other side. The familiar clinical picture of advanced tuberculosis with its attending distressing symptoms of vesical involvement, constitutional manifestations, such as pyrexia, night sweats and loss of weight, is sad and, inasmuch as it could be avoided, regrettable; but even such cases are not too infrequently treated for chronic cystitis, a term which should be eradicated from the working vocabulary of the medical practitioner, unless its clinical entity may be definitely proven by a thorough urological investigation.

Other urological conditions may overshadow the presence of tuberculosis and this constitutes rather a common source of error. Such cases may go unrecognized for many months and years, and are usually treated for the lesion originally diagnosed. To this type of cases belongs the patient who had had the misfortune of having gonorrhea either of recent date or even years ago and then develops a tuberculous swelling of the epididymis. While statistical evidence points to the fact that a renal calculus does not predispose to renal tuberculosis, the simultaneous occurrence of both is by no means uncommon. It is also uncommon to see such cases treated for either one of those afflictions, either without recognizing the presence of the other, or attributing the symptoms to the wrong ailment.

The following case histories were selected from a series of seventeen, which has come under my observation within the last two years, with the view of bringing forth the important diagnostic points in relation to the tuberculosis of the genitourinary tract.

* Read in part before the Alumni Association of Fordham Hospital and the Yorkville Medical Society.

Case 1.—J. M. Male, single, born in U. S.; occupation, chauffeur, age 22. One year ago was discharged from the military service. Denies emphatically gonorrhoeal infection. Following the discharge from the army, he began to complain of frequent, urgent, and painful urination, weakness, lassitude, afternoon fever and constipation. These symptoms lasted fully a year, until the act of micturition was accompanied with such agonizing pain that life became unbearable. Patient was out of work most of the time, as he could not hold position longer than a week or two on account of increased frequency of urination. There was an urgent desire to empty the bladder every ten or fifteen minutes, and patient had to get up at least ten times at night to urinate. He was told he had gonorrhoea and a stricture, and was treated for same for about four months, until he came under the care of Dr. F. G. Miller, who referred him to me in October, 1920.

On examination the patient was fairly well developed but somewhat undernourished. Temperature 100° F. The external genitals apparently normal. No. 26 F. curved metallic sound entered the bladder, meeting no obstruction. The prostate gland and seminal vesicles normal and their respective secretions contained no pathological elements. The catheterized bladder urine was pale, hazy and acid in reaction, contained albumin and numerous pus cells in clumps. Bacteriological examination showed sterile pus. No tubercle bacilli were found after an exhaustive search.

On cystoscopic examination the bladder was found to be of about 100 c.c. capacity and extremely irritable. There was a loss of normal lustre of the mucosa, the entire bladder being covered by dirty whitish plaques of cystitis and a number of typical tuberculous ulcers. The trigone was extremely congested, and was the seat of extensive bullous edema. The left ureteral orifice was represented by a large round depression, but because of severe cystitis the right orifice could not be visualized, being embedded in the swollen mucosa. The urine obtained from the left kidney, with the exception of occasional pus cell, was normal. The phenosulphophthalein injected intravenously appeared at the end of four minutes—good concentration. No color obtained in the bladder urine which represented the urine from the right kidney, a clear indication that the function of the right kidney was seriously hampered by some destructive processes. The radiological examination was negative.

Although several subsequent examinations of the urine for tubercle bacilli and a guinea pig inoculation were negative, I felt certain that I dealt with a case of advanced renal tuberculosis on the right side with extensive bladder involvement.

I lost tract of the patient until July, 1921, when he communicated with me requesting that I call to see him at Bellevue Hospital, Dr. E. L. Keyes' service. His general condition was very much worse, and this time there was a large swelling of the left epididymis. After numerous daily examinations, few tubercle bacilli were finally found in his urine. Left epididymo-orchidectomy was performed. Patient had a stormy convalescence and after his temporary discharge from the hospital was sent to the country for recuperation. He felt better for a while, but soon began to get frequent attacks of chills and fever. A right nephrectomy was performed September, 1921. Numerous tuberculous abscesses were found throughout the entire extent of the kidney, and in the lower pole there was an abscess cavity, the size of a silver dollar. The ureter was greatly thickened, and about one ounce of pus was drained from the kidney. The histological findings were those of tuberculosis.

The condition progressed to such an extent that surgical interference afforded little possibility for permanent relief. Although his general condition has considerably improved and patient has gained twenty pounds in weight, the urinary symptoms continued to persist after the nephrectomy.

One may with reasonable safety assume that when a young unmarried male adult, presents his case to a physician behind closed doors, he has no reason to deny venereal disease. Everything may be gained by believing the patient. An earlier diagnosis in this case would have meant comfort and, possibly, prolongation of the patient's life. Another point to remember is that sterile

pus in a catheterized bladder urine, having an acid reaction should at once point to tuberculous infection. The acid fast bacilli, however, will be practically always found, if searched for long enough, and often enough. There are periods, it is true, when tubercle bacilli disappear from the urine. In such cases, the best procedure is to make daily painstaking examinations until one's efforts are crowned with success. The slide should never be discarded until it has been examined for at least one hour, and even then it may be again looked over at some other time.

On the other hand, it must be emphasized, that the mere finding of tubercle bacilli in the urine obtained either through ureteral or the ordinary bladder catheterization, does not by any means constitute a proof of tuberculosis of the genito-urinary tract. In the process of breaking down of an old tuberculous lesion anywhere in the body, numerous tubercle bacilli may be discharged into the blood stream, which by filtering through the glomeruli of the kidneys will appear in the urine without actually invading the renal structure. We must, therefore, view with reservation any positive laboratory findings unless other clinical evidences are present, such as pain in the back, vesical irritability, persistent pyuria without an apparent cause, hematuria and the characteristic lesions of the ureteral orifice on the affected side as revealed by the cystoscope. It goes without saying that the examination of the voided specimen of urine is entirely useless as the presence of acid fast smegma bacilli may lead to an erroneous diagnosis.

Albuminuria is another more or less constant urinary finding and is usually due to associated nephritis of the affected kidney or, very frequently, to toxic nephritis of the opposite kidney. The prevailing notion that albumin derives its origin from pus is wrong and must be discarded.

The increased frequency of urination is so insidious, may be so slight in the early cases of renal tuberculosis, that little, if any, attention is paid to it. The frequency may even temporarily disappear, lulling the patient into a sense of false security. In the beginning the frequency is usually due to the irritant action of the acid urine, but as the disease progresses, actual invasion of the bladder mucosa takes place, and it is then that urgency, severe pain and burning at the end of urination, nocturia and in very protracted cases, incontinence manifest themselves. As in the above case, throughout the entire course of the disease, there may be only bladder symptoms, without any referable to the affected kidney, which accounts for the fact that the latter is so often overlooked as the underlying cause of the trouble.

It is remarkable how much damage may be done to a kidney without producing any renal symptoms, and it is a matter of common experience to see cases of grave renal infection which are ambulatory and free from any severe constitutional toxic disturbances. These points are illustrated even more strikingly by the following cases.

Case 2.—A. C., age 30, housewife, married, two children, referred by Dr. J. Haas in November, 1922. Has never been ill before. About five months ago patient began to complain of frequency, urgency, and burning on urination. She consulted an eminent gynecologist, who diagnosed the case as a chronic cystitis, and advised bladder irrigation. The patient also had a relaxed pelvic floor which was treated by pessaries. Bladder irrigation brought no relief. There was a desire to urinate every half hour and patient had to get up six or seven times at night to empty her bladder. Urination was accompanied by agonizing pain. She lost about thirty pounds in weight within four or five months. At no time did she complain of pain in the back.

On physical examination the patient was well developed but showed signs of wasting. Temperature 100.2 degrees F. Ab-

dominal palpation revealed no enlargement of the kidneys. The vaginal examination disclosed a relaxed pelvic floor, bilateral lacerations of the cervix and a retroflexed uterus.

The catheterized bladder specimen of urine was milky in color, with a reddish hue, and on standing fully one quarter of its volume was precipitated as thick, greenish pus which did not flow off the bottom of the glass on decanting. There was a heavy trace of albumin, and in addition to pus many red blood cells were found.

The cystoscopic examination revealed an extremely irritable bladder of about 100 c.c. capacity. The mucosa was intensely reddened and edematous throughout the entire extent of the bladder. The right ureteral orifice, being embedded in the swollen mucosa of the bladder, was visualized with great difficulty. The left ureteral orifice was plainly visible, intensely inflamed, ulcerated, somewhat retracted and situated at a much higher level than the right orifice. Thick greenish pus was seen discharging from the left ureteral orifice in a ribbon-like fashion, similar to a paste from a collapsible tube. Just beneath the orifice a large, deep retracted ulcer, which presented a shelf-like appearance was seen. No 5 F. catheter entered the right renal pelvis without any obstruction. The urine obtained from the right kidney was negative. Indigo carmine injected intravenously appeared in it at the end of six minutes. Concentration excellent. On the left side the catheter was arrested at 10 cm. above the uretero-vesical junction. No flow was obtained from the left kidney, due undoubtedly to the thickness of pus. On washing out the ureter with a sterile saline solution the return flow was found to be studded with innumerable pus cells in clumps. No trace of the dye was obtained at the end of twenty-one minutes on the affected side.

The bacteriological examination of the pus showed numerous Gram positive diplococci, Gram negative cocci and a few Gram negative bacilli. No tubercle bacilli were found after an exhaustive search.

The radiological examination with the shadowgraph catheters in both ureters revealed no calculi anywhere in the urinary tract. Both kidneys appeared to be enlarged. The left kidney was striped with areas of decreased density, which indicated some destructive processes in the kidney. It was plain that surgical interference was indicated in this case, therefore, no further attempts to ascertain the bacteriological status were made.

Patient was operated on December 7th, 1922, at Long Island College Hospital, where a left nephrectomy was performed. The kidney was much enlarged and found to be the seat of multiple abscesses. The histological examination of the sections from the removed kidney disclosed typical tuberculous changes.

Case 3.—I. C., age 51, married, occupation tailor. Had gonorrhoea in youth. About two months ago developed a painless swelling in the right testicle, also frequent and somewhat painful urination. On the strength of the previous history of gonorrhoea the case was diagnosed as gonorrhreal epididymitis and treated with irrigation and instillation until he developed a slight hydrocele, which was tapped. The patient finally came under observation of Dr. C. Weiss, of Brooklyn, who referred the case to me in February, 1922.

On examination, the right epididymus was considerably enlarged, indurated and somewhat tender. The prostate gland was bilobal, small and of peculiar stone-like hardness. The right vesicle was tremendously enlarged. The catheterized bladder specimen was pale, hazy, contained a trace of albumin, numerous pus cells and numerous tubercle bacilli. On cystoscopic examination the bladder was found to be of normal capacity, mucosa congested at trigone and a moderate degree of trabeculation was present. The right ureteral orifice was inflamed and gaping, the left apparently normal. The segregated urines showed pus and tubercle bacilli on the right side, normal urine on the left side. The phenosulphonephthalen injected intravenously appeared in the right urine at the end of four and one half minutes, and in the left urine at the end of five and one half minutes. Good concentration on both sides.

Patient was operated at Mount Sinai Hospital, Dr. Edwin Beer's service, where right epididymectomy was performed in March, 1922, and right nephrectomy two months later.

The point to be emphasized in this case is that while an antecedent history of gonorrhreal infection may be of value, inasmuch as the latter may predispose to tuberculous infection, in the vast majority of cases it has probably no bearing on the case if occurred at such a long lapse of time. Gonococci disappear from their hiding places in the genito-urinary tract at the end of three or four years even without any treatment, and if that is borne in mind, we should with great hesitancy subject our patients to punishment for the sins committed in their youth.

Case 4.—P. R., age 19, female, single, born U. S., occupation stenographer, referred to me by Dr. A. D. Berow in October, 1921. For the last four months patient began to complain of frequent and painful urination, cough, pain in chest, loss of weight, and general weakness. She consulted her family physician who treated her for chronic cystitis but with no relief.

On examination, patient was a slightly built girl, emaciated and anemic, with sunken cheeks and a narrow chest. The catheterized bladder urine was hazy, contained albumin, many pus cells and innumerable tubercle bacilli. On cystoscopic examination the bladder was found to be covered in the region of the trigone with flakes of adherent mucopus, and the mucosa much reddened. The left ureteral orifice was edematous, the orifice somewhat ulcerated and retracted. No. 6 F. ureteral catheters entered both renal pelvis without any obstruction. Right urine—normal flow, negative microscopical findings. Left urine—obstained in a continuous flow, indicative of a hydronephrosis. Microscopical examination—numerous pus cells and tubercle bacilli. Phenosulphophthalein—excretion good on the right side, fair on the left.

It was deemed advisable to send the patient to the country in view of her poor general condition. She gained ten pounds within a period of eight months, and in June, 1922, left nephrectomy was performed at the Saint Marks Hospital by Dr. M. F. Goldberger. The kidney was found to be the seat of multiple tubercular abscesses, and the ureter greatly thickened for about four inches from the renal pelvis. The histological examination showed typical tuberculous changes.

Cough and frequent painful urination in a young adult often spell tuberculosis. While irritability of bladder is by far the most common symptom of renal tuberculosis, cases occur where hematuria is the first indication of the trouble, similar to hemoptysis in pulmonary phthisis. It may be a very early and the only symptom. If it occurs and disappears, great care should be taken not to dispose of the case as essential hematuria. As our knowledge regarding the obscure causes of hematuria increases, and with the advent of modern diagnostic methods in urology, such as pyelography, renal function tests and various mechanical cystoscopic procedures, the term essential hematuria is rapidly falling into disrepute. The hematuria in renal tuberculosis may be either slight and disappear in the course of two or three days, or it may be so severe as to demand nephrectomy as a matter of expediency.

Case 5.—J. G., age 40, married, occupation presser, was referred to me by Dr. S. Felder in June, 1921. Family and previous history unimportant. One week ago patient suddenly began to pass blood in his urine. The hematuria was very profuse, the patient passing large blood clots, and there was a slight burning on urination. The radiological examination of the urinary tract failed to disclose any calculi. On cystoscopic examination the left ureteral mound was "reattly tumered, due to the lodgement of a blood clot in the lower ureteral segment. The clot was seen protruding from the ureteral orifice. The urine contained no pus cells, and no tubercle bacilli were found. Following the cystoscopy the patient continued to bleed profusely, until other symptoms of very severe internal hemorrhage made their appearance. Left nephrectomy was performed with the view of arresting the hemorrhage, and a large tuberculous cavity was found in the affected kidney.

Pain in the back may be an early and an important symptom and, in hemorrhagic cases, may even simulate a typical attack of renal colic, due to a clot blocking the ureter. Usually it is of a dull, aching type occurring either in the costo-vertebral angle or anywhere in the lumbar region posteriorly on the affected side. In unilateral involvement pain may be also experienced over the sound kidney due to the so-called "renal reflex."

Case 6.—J. V., age 36, married, occupation saloonkeeper, born in U. S., was referred to me by Dr. A. Rosenberg in July, 1922. Previous history, had three attacks of gonorrhea fifteen years ago. Heavy drinker of whiskey for the last fifteen years. Present history, began to complain of dull, steady ache in both costo-vertebral angles, occasionally shooting down to the glans penis. About two months ago had a slight frequency and burning on urination, which has subsequently disappeared. Consulted his physician for pain in the back. Physical examination, patient rather well developed and nourished individual with alcoholic facies. Blood pressure, 140, systolic, and 90, diastolic. Liver palpable one inch below costal margin, presenting uni-

formly sharp, firm border. External genitals apparently normal. The prostate gland bilobal, well outlined and of uniform firm consistency. The expressed secretion was full of pus cells, but contained no gonococci. The catheterized bladder urine was hazy, contained a trace of albumin, numerous pus cells and numerous tubercle bacilli. The cystoscopic examination revealed intense congestion of the trigone. Both ureteral mounds were somewhat bulging, especially on the right side, and inflamed. No. 6 and No. 5 F. catheters were arrested at 3 cm. above the left uretero-vesical junction but No. 4 F. olive tip variety passed up without any difficulty. Moderate number of pus cells and tubercle bacilli were found in the segregated urines from both kidneys. The phenosulphophthalein obtained in the left urine at the end of six and one half minutes. Concentration, good. No color obtained on the right side, due to stoppage of the urinary flow, following the administration of the dye.

The radiological examination revealed the left kidney to be larger than the right, the renal shadow being strippled with areas of decreased density. No calculi anywhere. Wasserman negative. With such bilateral involvement, surgical intervention, was, of course, contra-indicated.

While it is true that in the vast majority of genital tuberculosis there is a conspicuous loss of body weight and demonstrable tuberculous lesions, either active or dormant, are present elsewhere in the body, it is also a matter of common experience to see those cases co-exist with the excellent state of health. Genital tuberculosis as all evidence points, begins in the epididymis. Frequently there is a preceding history of trauma. The onset, as a rule, is so insidious, the swelling and tenderness so slight, that it is usually many months after the onset of the disease that the patient seeks medical advice.

Case 7.—S. P., age 28, married two years, occupation cutter, born in Russia, was referred to me in August, 1921. Previous history, gonorrhreal infection denied. Was operated for left inguinal hernia two years ago. Soon after the operation he noticed a slight lump in the left testicle, which was painless and gave him no concern. While sexual desire and erectile power were normal, he, nevertheless, consulted several physicians for sterility. Has always enjoyed good health. No urinary symptoms.

On physical examination patient was a very well developed and nourished individual, weighing about 180 pounds. The voided specimen of urine was sparkingly clear and on microscopical examination contained no pathological constituents. The left epididymus was slightly enlarged and somewhat indurated. There was a cystic mass, size of a small cherry, connected with left spermatic cord near its epididymal extremity. The testicles were normal. The left vesicle was somewhat distended and the expressed secretion proved to contain numerous pus cells, no spermatozoa and a few tubercle bacilli. The condom specimen also revealed a complete azospermia.

Epididymectomy was decided upon, but on the eve of the operation the patient developed a swelling of the right epididymis, which was rather painful. The epididymis was removed two weeks later by Dr. Harry Cohen, and found to be the seat of cheesy necrosis. Anastomosis between the vas differens and the testicle was performed with the hope of curing his sterility. The histological findings were those of tuberculosis.

The important point to bear in mind is that tuberculosis of the epididymis, unless complicated by the secondary involvement of the seminal vesicles and the prostate, or unless associated with the renal tuberculosis (as in case 2) gives rise to no symptoms of bladder irritability, which also accounts for the fact that these cases appear late under observation. The above case represents a striking illustration, although a rather infrequent one, of sterility, the underlying basis of which is a tuberculous occlusion of the vas deferens.

That even an active tuberculous lesion of the kidney may be entirely symptomless is illustrated most strikingly by the following case.

Case 8.—G. S., age 28, single, occupation—travelling salesman, was referred to me by Dr. L. Greenwald in June, 1922.

Five years ago patient had an attack of what he was told was gonorrhea. The attack has subsided, but has recurred two years later. Ever since the first attack patient has had cloudy urine.

(Concluded on page 130)

SYMMETRICAL LEUCODERMA IN A SYPHILITIC*

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and
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Depigmented areas of the skin in syphilitics are more or less widely encountered. The symmetrical arrangement of some of these has called for comment in the past, and the suggestion that a nerve lesion was the basis of such depigmented areas has been made. The following brief case report is thought worthy of interest, and the illustrations accompanying suitable for publication.

Case Report

A. K., a Greek, aged 45, and a cook by occupation,



reported to the clinic at Bellevue Hospital on March 22, 1922. He has been an inmate of the surgical wards for upwards of a month because of injuries sustained in an automobile accident. He denied any knowledge of syphilitic infection, despite a routine ++++ Wassermann. On direct questioning, however, we were able to learn that some 13 years previously a lesion of the prepuce had been present, and treated with local applications. This sore had disappeared and no subjective symptoms had come to the patient's attention which could lead him to believe that the lesion had been other than a local one. About a year previous to coming to us, the patient had noticed white patches appearing on his skin, but he gave little heed to them. He could not definitely say that any area had increased or that new areas had appeared since the disease first made its appearance. The photographs tell better than words the character and extent of the eruption. The symmetry was a point which was very evident.

The Wassermann repeated at our clinic was +++. The patient was placed under antisyphilitic treatment, and after a course of arsphenamin and mercury the Wassermann was reduced to +. A spinal puncture was done. The cells were 3 to the cmm. The globulin test was negative. The Wassermann was negative to numerous dilutions. The colloidal

gold was 000000000. The physical examination revealed a very obese male, with white patches of the skin symmetrically placed about the face, abdomen, scrotum, and buttocks. There was an internal



strabismus of the right eye. The pupils reacted to light and accommodation. No abnormal findings were found in the chest or abdomen. The breasts were protruberant, and the abdomen hung low. This may have been an indication of dystrophy of the sex glands, but speculation does not help us. Clinical examination of the nervous system by the resident neurologist of the hospital (Dr. Morris) was reported negative.

The interest in this case lies purely in the appearance of the skin eruption as to its symmetry and the absence of pathological findings of the nervous system either by clinical or laboratory methods.

Tuberculosis Among the Colored in the United States

The United States Bureau of the Census has just made available figures of the tuberculosis death rate among the colored in eleven States included in the Registration Area numbering a total of 5,734,056, according to the last Federal census in 1920. These Census Bureau reports separate the mortality returns of the white and colored populations in States within the Registration Area which contain a population of over 200,000 colored people in each.

The rates are strictly comparable, as they have been adjusted for differences in age and sex composition. In other words, they are the final rates that would be obtained if in all States the proportion of males and females and their age constitution had been the same in the total population under consideration.

The Census Bureau's designation of the colored includes other racial groups than the Negro, but is practically all composed of the latter.

It is interesting to note that under more natural conditions of living—at least to the Negro race—there is a much lower tuberculosis mortality than in the northern congested and colder cities. The lowest death rate during 1921 among the colored occurred in Florida, where it was 160 per 100,000 population. A mortality twice as great occurred in New York, Pennsylvania and Kentucky. Still higher rates in the northern States were common a few years ago. In New York City, for instance, the tuberculosis mortality among the colored rates 507 in 1910.

During 1921, as against tuberculosis death rates among the colored, ranging, as above, between 160 and 326, the death rate in the entire United States Registration Area for both groups of the white and colored population was 99.—(Bull. N. Y. T. B. Ass'n.)

The Wolfian body (the mesonephros or primitive kidney) gets its name from Caspar Friedrich Wolff (1733-1794), German anatomist and physiologist, who is generally reckoned the founder of modern embryology.—(Med. Facts.)

* From the Dept. of Syphilology, Bellevue Hospital.

Boards of Health for the Mind*

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I think that it is very generally recognized at the present time that there are a great many unfortunate suggestions finding their way into the minds especially of the younger and more suggestible folk in our generation which are actually doing a great deal of harm. Some of these suggestions come from the ordinary daily life, but most of them come from printed sources, though not a few of them are the result of modes of entertainment that are popular in our day. We are looking on and doing almost nothing to neutralize these unfavorable suggestions or to use public means of various kinds for favorable suggestions because the problem seems so difficult that it appears almost impossible to solve it and so many abuses would be connected with its solution, or threaten to be that we hesitate about it and allow the evils to go on almost unchecked.

As the result, for instance, of the publication of details of suicides and especially of combinations of suicides and murders a large number of minds that are not exactly disequilibrated but are balancing on the verge of disequilibration are pushed over into the commission of crimes that otherwise would not take place. We all know the significance and influence of suggestion in these conditions. Suicides are prone to occur in groups of the same kind and it is evident that there has been a tendency to imitation created. Murder and suicide together runs something of the same way. There was an old proverb that such things ran in threes and that was considered by many to be mere coincidence, but we realize now that there was a real causative connection because of the influence of suggestion.

Contrary suggestion has been known to play an important role in the prevention of such crimes. There is an old story with regard to one of the smaller Grecian islands that is very interesting in this regard. A number of the young women under the leadership of one of them who despised matrimony and thought its duties and obligations a distinct descent to the animal, organized themselves into a society who, as they came to marriagable age, took their lives rather than submit to the unworthy association of this demeaning practice. The evil became so great that the magistrates scarcely knew what to do about it. Finally they decided that only some striking contrary suggestion might help though of course 2500 years ago they would not have worded it that way and so they announced that the body of every woman who committed suicide would be dragged naked through the market place at the tail of a donkey. That is said to have put an end to the suicides' pact. We have had much more modern examples in which the refusal of religious burial or the burial at the cross roads with a stake through the body has undoubtedly lessened the number of suicides.

Some of the immense amount of harm that newspapers can do by suggestion is very much illustrated from an incident in Chicago in very recent years. A race riot was on. A negro had insisted on bathing

on a part of the beach of the lake front, by convention reserved for whites. Perhaps he had not quite intended it. He was seriously hurt, or possibly even killed in the row that took place. That inflamed race fury and for several days the race riot continued. Twenty negroes and fifteen whites lost their lives and 537 people were injured. Chicago may seem far north for that, but this was only one episode and Omaha, Washington and Boston, even, had outbreaks of bitter race feeling. The Chicago committee on race relations, appointed soon after the riots, has just published, through the University of Chicago Press, the results of its investigations. With that we have little to do except in so far as it relates to the newspapers.

The three most important Chicago newspapers on one day while the riots were on published a circumstantial account of the storming of an armory where arms were stored, by a band of negro rioters, who wished to arm themselves in order that they might shoot down the whites. The commission reports that there was no such attack upon the armory by the negroes and that if there had been it would have done them no good for there were no arms stored there, but besides so far as can be ascertained there was never any question of any such thing. No one thought about it at all, except the reporter who realized that this would make an awfully good story to attract attention and then once it was published, other papers thought the same thing and proceeded to scatter broadcast the same inflammatory news.

Could anything be more likely to do harm under such circumstances. And yet the three most important newspapers in Chicago proceeded to publish this item of news. Undoubtedly it worked immense harm, inflamed passions and the surprise is that it did not bring about many more murders than actually occurred. Is there any tribunal before whom the newspapers can be cited for such a breach of faith with the public? Apparently not. Is there any procedure by which they can be prevented from doing this same sort of thing in the future? Absolutely none at all. The freedom of the press must not be shackled. But of course this is not freedom, it is license and the difference between liberty and license should be well understood. You are not free to do harm, though you should be free to do good. You are not free to foment discord among citizens and to encourage violations of law, though of course you should be free to encourage such law making as will benefit people.

The incident illustrates very well the conditions that exist in newspaper publications. They want to attract readers, not for their readers' benefit, though that is so loudly proclaimed, but because the more readers they have the more they can charge advertisers and the more money there is in the papers. If there is anywhere that Macchiavellian principles rule it is in newspaper offices, as a rule, though there are some honorable exceptions, and, thank God, their number is growing. The one idea is give the people what they want and it will make them buy the paper.

After all the policy that dictates the publication

* Read before the Society of Medical Jurisprudence at the Academy of Medicine, New York, February 12, 1923.

of such news items is not a whit different from that which publishes suicides and combine suicides and homicides and sex crimes of all kinds in all their lurid details because these will sell the paper. What difference does it make even if it is manifest that they do palpable harm. What tribunal can the newspapers be cited before? If they libel an individual they are responsible in damages, but for doing immense harm to the public they have no liability at all.

There is no doubt at all, however, that suggestion plays a very large role in even these crimes toward which nature has such a distinct abhorance. It is easy to understand, then, that where natural deterrence is replaced by natural attraction, suggestion may be even more unfortunate in its effect. We all remember how the dime novels of a generation ago used to send a certain number of boys, armed with revolvers, if they could get them, but pistols and poniards at least, westward to be road agents or to imitate the Jesse James gang, or to be Indian hunters. Of course the boys got bravely over this, most of them, but it must not be forgotten that during the war the intelligence test made among the drafted men, nearly two million of them, showed that the average intelligence age of our men between twenty-one and thirty-one in this country is only about that of the boys who used to be so ready to take suggestions from their reading, and leave home for the west in search of adventure. We have an immense, extremely suggestible population. No wonder that the police declare that to show pictures of successful pickpocketing or purse picking on the street cars or of venturesome second story workers who shin up porches while the family is at dinner and cop their money and jewels, is likely to bring about a series of attempts at such crimes not long after the picture has been seen.

That word suggestion is interesting and but little understood. It comes from the two Latin words *sub* and *gero* which mean I carry under. The past participle of *suggero* is *suggestum*, the root of our word suggestion. A suggestion then is an idea that goes into the mind under the ordinary barriers of attention and discrimination and finds a place there without having been submitted to our critical judgment. All of us have a great many suggestions that got into our minds when we were young, some of them good and some of them bad, the source of which we would find it extremely difficult to trace out. Children unable to think for themselves are always taking suggestions. A great many grown people are extremely suggestible. We have a definition of hysteria now that we did not have before. It is in a single word, though a rather long one. Hysteria is supersuggestibility, an excessive tendency to take suggestions. We used to think that hysteria was entirely limited to the female sex, but during the war many thousands of cases of so-called shell shock which were really true hysteria, occurred among our young soldiers, and we know now that under certain strenuous critical circumstances men may be quite as hysterical as women. Many conditions have made our generation, male and female, ever so much more suggestible than they used to be. We think less and above all weigh matters less. Nearly everybody takes suggestions rather readily.

The extent to which we have cultivated suggestion, or rather suggestibility is enormous. There are an

immense number of things that we read without paying very much attention to them and if we read them over and over again they come to have a place in our minds which influences us in many ways. The advertiser knows that all that he needs to do is to keep on saying it over and over again until we get used to the thing, and then we ask for it. What an immense number of people there must be who use this or that soap just for no other reason than that they have seen the name so often. You can attach almost any idea you like to it that "it gives you that clean feeling," or "that clean smell" use it and feel clean, but as a rule the less you have to do with reasons the better, just keep on saying it. That first great prince of world advertising, Pears, made his success simply by repeating "Good morning have you used Pears' soap?" The bill for advertising in this country is represented by billions of dollars. It is in the vast majority of cases an utterly useless expense and it is the buyer that has to pay for it. Bargain sales are bargain sales, but the people who bought the first lot of those goods had to pay not only the higher price required to enable the seller now to sell at cost or a little less, but also to pay for the immense bill run up in advertising the bargain sale. Sometime or other we shall realize the immense influence of suggestion. As yet we seem not to.

If this is true with regard to deterrent and also indifferent things it is easy to understand what an effect upon the minds of young folks particularly the avalanche of suggestion that is poured in upon them with regard to sex matters for instance produces. Young folks just about the time that their sex feelings are waking up are practically given to understand by all their reading in the matter that it is a sign of manliness and womanliness to be overcome by such feelings and that it is quite beyond the possibility of human nature to get along without some indulgence of them at least. The newspapers are full of sex crimes, the magazines are full of sex stories, a whole series of magazines are published with no other idea than to attract young people because of the sex feelings which they arouse by their stories. The magazines are named with that idea. Snappy Stories, Saucy Stories, I Confess, The Ginger Jar, The Pepper Pot and any number of others. The most popular magazines are those that have the deepest sex appeal, that is that are full of stories in which the lives of people are related who seem to have nothing else to do except to properly work themselves up to and then let themselves down from sex experiences of various kinds. That is quite literally pandering to the sex feelings, pander is the word for it. It is a provision of material to be quite frank for mental masturbation.

The extent to which such magazines are read by the young, and especially the better-to-do young women who have nothing very much to do,—it is curious that better-to-do and nothing to do should thus come together,—is ever so much greater than is usually thought. Indeed it is quite surprising the extent to which such things circulate and extend their influence. The manager of a rather important magazine in this country which has quite a wide circulation once went to the advertising agency which is known to handle more of the advertising of girls schools in the United States than any other. He wanted to share in that advertising. He was asked by the

advertising agency's manager "What magazine in this country do you think by actual keying of advertisements has been found to give by far the best results for its advertisements of girls schools". My friend replied, "Oh I suppose *Harper's* or *Scribner's* or some of the old line family magazines which lie on the table at home during the month and are picked up by father and mother and the girls." And the advertising agency manager said, "That is not our experience. The best medium for such advertising is"—and then he named a magazine that is noted for practically publishing nothing but sex stuff, but which also carries a large line of the advertising of girls schools.

Manifestly the girls themselves read the magazine and read also the advertisements in it rather faithfully and they pick out the schools they want to go to and of course they go. Whatever a child wants to do it must be permitted to do anymore. A writer in the *Atlantic* said not long ago, "There is just as much obedience as ever in the American family as there ever was, only now the parents obey the children." Daughter having picked out the school she had made up her mind to attend from the columns of her sex stuff magazine, went there. As for the advertisements and their place in that magazine and the suitability of it, I suppose that all that need be said is that if an advertisement for their school inserted in the register of a bawdy house would bring them pupils, that is all that the school authorities would care for. Doubtless they have handed over their advertising campaign to an advertising manager and his slogan is to get results, it does not matter how you get them.

It would remind one very much of the college faculties and university boards who accepted very gladly the advertising that athletics afforded them until now athletics has grown into a giant who is giving them a lot of trouble to manage. They have raised up a Frankenstein that now proposes to run the colleges to a great extent rather than be run by them. It is, after all, only another manifestation of that tendency to have our bodily interests run away with us that is so marked in our time.

As the result of all this sex suggestion everybody has come to realize that the young folks must be protected against it and the curious notion has developed that the way to do it is to tell young folks all about sex. It is hard to know where any such idea came from because it is such a contradiction of all our ordinary knowledge of things and of all commonsense psychology. Our courts are filled with divorce proceedings begun as the result of actions by people at ages when they know all about sex. Sex divagations of various kinds I venture to say are commoner among married folk whose knowledge surely is not lacking than among the unmarried. The older a man gets until enlargement of his prostate interferes with function the more he is likely to be foolish in such matters. Even then, when a provident nature has greatly lessened his concupiscence he is prone to take damiana or some other supposed aphrodisiac or to have himself injected with monkey glands so as to be able to go on with it.

If there is any place in the world where knowledge is not protective and where knowledge is not power for self control, it is in sex matters. Medical students always know much more about these subjects and also, be it said, about the dangers con-

nected with them, but I need scarcely say that they are not noted among the university students for the austerity of their virtue. They read all about these matters just as soon as they settle down to study medicine. You will find those portions of their textbooks thumbed and worn, you can take one of their books off the shelf and without opening it note exactly the part of it which treats of the anatomy and physiology of the sex organs, and even in their surgeries which treats of the diseases of the sex organs by simply looking at the closed books and without opening them.

There is in human nature a special allurement to read about these things and even reading sex pathology sets up certain interested feelings that may, under certain circumstances cause quite a glow of excitement.

Sometimes it is supposed that such results occur only among the young, but I shall never forget an extremely interesting experience that I had in Paris with this subject. Prof. Thoinot, a professor of medical jurisprudence at the University of Paris was lecturing on stupra of various kinds, violations of the young, not so much those that involved actual sex relations as touches of other kinds and the medico-legal aspect of them.

Thoinot's course was not compulsory for anyone. I was rather surprised then to find how crowded the lecture room was, but I was still more surprised to find the character of the audience. There were at least 500 there, but I doubt if 100 were medical students. The audience consisted of at least four-fifths old physicians. They listened with wrapt attention to Thoinot's rather detailed descriptions and then got up with a sigh of manifest wish that there were more of that sort of thing, but manifestly also perfectly resolved to come back the next week to hear what might be said further.

Possibly it might be thought that this is typically French, but anyone who thinks so ought to have gone with me the following semester to Vienna to have seen how Kraft Ebing's lecture room was crowded, not so much by students who really bothered their heads very little about it, but by practitioners, many of them rather well on in years who, while losing potency themselves, evidently liked to hear about all sorts of curious manifestations of the sexual instincts.

I have sometimes feared that my thorough-going adherence to old-fashioned traditions on the subject made it rather difficult for me to see and understand the modern view of sex knowledge being protective. Twenty years ago I got to know and think a good deal of Prof. Munsterberg of Harvard. I suppose that two men have seldom been brought up at such opposite poles of thought in their younger years and we were, and therefore when I found that he agreed with me with regard to the influence of sex suggestion, and not only the absolute lack of any protection for young people in sex knowledge, but even the emphatic assurance that such knowledge would prove rather harmful than otherwise because of the mechanism of reinforcement which it so constantly calls up, some passages from his works were very deeply impressed upon me. He once said, for instance, when the question of teaching sex hygiene in the public schools first began to be discussed:

"The cleanest boy and girl cannot give theoretical attention to the thoughts concerning sexuality without the whole mechanism for reinforcement automatically entering into action. We may instruct with the best intention to suppress, and yet our instruction itself must become a source of stimulation which unnecessarily creates a desire for improper conduct. The policy of silence showed an instinctive understanding of this fundamental situation. Even if that traditional policy had had no positive purpose, its negative function, its leaving at rest the explosive sexual system of the youth, must be acknowledged as one of those wonderful instinctive procedures by which society protects itself. . . .

"A nation which tries to lift its sexual morality by dragging the sexual problems to the street for the inspection of the crowd without shyness and without shame, and which wilfully makes them objects of gossip and stage entertainment, is doing worse than Munchausen when he tried to lift himself by his scalp."

If what Münsterberg says is true, and I think that all of us who have gone through our own youths in reasonable health and vigor must think so, then most of our modern printing is a sad commentary on our psychology. If even the cleanest boy and girl cannot give theoretical attention to sex matters without the whole mechanism for reinforcement automatically entering into action, then what must happen when clever authors devote themselves to making these subjects as alluring as possible. The mere fact of occupation of mind with them in any way is serious enough and our newspapers play up sex stories to the very last degree. I had an editor boast to me not long ago that the sordid New Brunswick tale of two murders had made a record for itself by occupying a place on the front page for something like two months. This had never happened before. Just think of the number of people every day at breakfast who want to know all the morbid details of the sex crimes of the day before or of some other day before in the more distant past. They like to picture to themselves how it all happened and a great many of them must come inevitably to the conclusion, especially when they are young, that everyone does this sort of thing, only some have not yet been found out. The more sex stories can be made to smirch respectable people, the better the newspapers like it because they know that their readers care for this and that it will sell the paper. Sex temptations are an easy way of making money. Kipling calls the provision of them the oldest profession in the world. I am afraid he is right too.

We shall never get rid of sex temptations and allurements, but why should they be emphasized and why have life centre around the thoughts connected with them. There are people who say that is realism, that is what is true to nature, men and women are constantly thinking about these things. That is simply not true. We have two other functions situated in the same part of the body that may readily become the subject of much more solicitude than the sex problems. I suppose that every physician has had patients who have gotten their bowels so on their mind and the necessity for a daily formed stool had become such an obsession that they have become a nuisance to themselves and others. If you read the advertisements for laxatives you will see the truth of an expression of a friend of mine that what we need here in the United States is not

what Matthew Arnold suggested leading and light, but laxatives and more laxatives. On the other hand there are people who become very much disturbed over their urinary functions. Almost any irregularity in them will set them to worrying about them quite as much as these people who are so much occupied with their sex functions. When any receptacle of the body has to be emptied at intervals there is likely to be a tendency to this solicitude about them in people who have nothing else to think about and nothing to do that they have to do. Montaigne compared the climax of sex feeling to a sneeze. That comparison deserves much more serious thought than might at first glance be thought.

In our generation, however, sex suggestion and occupation with sex has become the rule. We have even evolved a philosophy of disease—and of life that attributes nearly all the incentives of existence and all of the nervous troubles apart from organic nervous disease to sex. All sorts of people have fallen for this new philosophy of life and the editors comment on the daily life around them in terms of it and the novelists write up its complexities and the dramatists stage its repressions and the troubles incident to them. What difference does it make if the prominent neurologists of the world are almost a unit in condemning the new mode of thought as dangerous, and its curative properties as only a repetition of ever so many cures that have failed, or that the psychologists of the world have proclaimed it not a system of thought but a mystic cult with a following of initiates, psychoanalysis goes on attracting attention because we are a sex centered age. There never was a time when there were so many nuroses noted as now, and we are told that they are due to sex repression, and there never was a time when there was so little sex repression as just in our time. No wonder that all sorts of sex divagations are rife because of the influence of the suggestion that goes with all this sort of thing.

Now what are we to do about it. Throw up our hands and let it go on? That was what they used to do in the old days with regard to contagious diseases, they just said to themselves it is a visitation from God, what can we do about it, and the disease worked its way, carried off its thousands and people waited for the termination of the epidemic and then for the next wave of it to come. Now we clean house, get rid of the rats, straighten out the water and milk supplies, eliminate the carriers from intercourse with the rest of mankind and the great epidemic diseases are on the wane and there seems to be no question that it will not be long before they will practically disappear. Until this last Great War practically always typhoid fever has carried off more soldiers than the bullets of the enemy, but now we have changed all that.

Why should we not do that same thing with the psychic contagion that is working so much harm among us. Newspaper accounts of suicides are, by suggestion, increasing the number of suicides. Newspaper details of combined suicide and murder are upsetting the equilibrium of many minds tottering on the brink of insanity and leading to these sad events which often are not crimes, though they are very unfortunate. In the same way sex suggestion is working its harm. It is leading young folks to think that it is almost impossible for anyone to go through even the early years of manhood or womanhood without sex experiences, it is making them be-

lieve that sex repression is really very harmful and that practically no one among the older people practice it, though some few of them have not been found out yet in their disregard of moral laws. Above all it is exciting human passions, calling up the mechanism of reinforcement, sending blood to parts of the body from which its effect is to produce an increased amount of aggravation of sex impulses until control of them almost veritably becomes impossible.

Even our libraries carry all sorts of fiction calculated to arouse sex feelings and reputable publishing houses are taking up the publication of books that are disgracefully obscene because there is money in them. Our theatres are packed with audiences seeing sex problem plays which it is very hard to understand that young folks of opposite sexes should see together without a loosening of that respect for each other and those inhibitions which enable them to protect themselves against certain impulsive instincts. Are we to do nothing in the midst of all this except let it go on? Must the rule be simply *caveat emptor*, let the buyer beware, that it is up to the buyer of a book or of a seat in a theatre to guard himself and if anything untoward happens to him because of his purchase, well that is his fault and we can do nothing to protect him nor to help him in any way?

This is the attitude of mind that prevailed largely with regard to health, a scant fifty years ago, that is about a generation ago, as generations now run. Dear old Dr. Stephen Smith told us the story of that in his book, *The City That Was*. The conditions had become almost unspeakable. I tried to tell the story briefly in a chapter of my *History of Medicine in New York* called *The Sanitary Revolution*. A thorough going revolution it really was. The conditions that had developed before they succeeded in getting such legal regulation no one could possibly believe were as close to us as this. When attempts were made to insist on the part of those interested in New York health to bring about reform, those whose property was involved proceeded to declare in no uncertain terms that it was no one else's business except the tenants' and the landlords'. If the tenants were willing to rent why should not the landlords take the money? They added in the high philanthropic spirit in which landlords so often indulge that if they kept the places in such good order as to prevent the conditions that existed, it would prove so expensive that the tenants would not be able to pay the rent so that the tenant house owners, as they were called then, really felt that they were benefactors of mankind.

Here is a typical example of what inspectors found in one place, and I may say that this is taken only as a type and there were worse places than this, and yet the physicians and the medical societies of that time could do nothing to bring about the cleaning up, even of this specific nuisance much less the reform of conditions that existed in many parts of the city.

"Five small houses, two and a half stories in height, including the basements, each containing apartments for six families, front on an alley called Rivington Place. This alley is always in a filthy condition. The houses on it are all small and overcrowded. The thirty families that reside in these five houses have no other water supply than that which two hydrants furnish in the exterior courtward; while for this population of nearly 200 persons, of all ages, there are but two privy vaults, and, at the time of the last inspection of the quarters, these vaults were filled nearly to the surface. In the year 1849,

forty-two individuals died here in three weeks of cholera, and not one recovered that was taken sick. The reasons are plain: they have no ventilation, and the houses being double, the exhalations from one apartment are inhaled by the occupants of the other."

(Concluded in June Issue)

A CONTRIBUTION TO NON-SPECIFIC PROTEIN TREATMENT

H. EDWARD AHLSWEDE, M.D.
Buffalo, N. Y.

Experiences of recent years in parenteral introduction of foreign proteins into certain cells or all cells of the organism in order to produce stimulation of their functions have overthrown a large portion of the early doctrines on the decomposition of alimentary proteins in the intestines. In comparatively recent handbooks on physiology one may still find passages to the effect that all proteins must be split to the state of the simple amino acids in order to be resorbed.

That this theory did not hold true for all cases was evident from observations made in various kinds of protein intoxications occurring in different bacterial diseases of the intestines. Then also it had been determined in pediatrics¹ that nonsplit proteins can be resorbed by apparently uninjured intestinal walls. Thus physico-chemical protection seems to be incomplete.

On the other hand, Funck² has determined that in numerous diseases of metabolism, f. i. in diabetes, high molecular protein cleavage products were present in the circulatory system; they had passed the otherwise impregnable barricade of the liver. Widal³ and his collaborators, in very painstaking investigations, have discovered that many diseases of uncertain etiology are in reality due to nonsplit proteins from the intestines entering the circulatory system by way of the liver.

For these reasons we are now ready to assume a similar etiology for such cases of urticaria as may be traced to the food of the patient and also for numerous cases of uncertain neuritides, increase in blood pressure, a. s. f. An example of the beneficial results often obtained in refractory conditions by seemingly unimportant measures of treatment is stated by Watelet⁴ who relieved an asthma case of long standing by internal administration of small doses of pepton.

Thus, there exist substances which in a nonsplit condition, as pure proteins, produce a therapeutic effect. Most of these proteins do not seem to be entirely non-specific. There is generally an affinity for the cells of certain organs. We are able, just as in parenteral introduction of proteins to produce a specific action on the cells of certain organisms by a selective combination of certain proteins. Such specific therapy of the organs has been attempted for some time by the administration of preparations of brain, liver and pancreas, etc. It is important to distinguish in each case between "stimulation of the organs" and "therapy by introduction of lacking substances".

Extensive research has revealed that it is not possible to count positively on a reaction to the enteral introduction of proteins as individual differences, due to sex, age and general condition of the patient are too great. Nevertheless, this method certainly aids in increasing the activity of the cell protoplasm.

In certain organic diseases which may be positively attributed to the absence of specific substances whose action resembles that of a ferment, we have lately instituted combined treatment. Our therapy is based on a general stimulation of all cells of the organism. For this purpose toxine and germ-free solutions of proteins have proved most successful. We give intramuscular injections of 10cc aolan, which are repeated after 2, 3 or 4 days, depending on whether the process is in the acute or in the chronic stage.

Combined treatment of aolan plus specific enteral stimulation therapy is indicated in all chronic diseases of metabolism, in which the affection of a certain organ is definitely determined, (diabetes, neurosis, epilepsy, etc.) In such cases as well as in arteriosclerosis, aneurisms and diseased conditions of the bone marrow very beneficial results have been obtained.

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SENSITIVE FINGERS AND THE TONSIL

HAROLD HAYS, M.D., F.A.C.S.,
New York

One has often heard the remark made that any tonsil which can be seen should be removed. In other words, all large tonsils are pathological. This may or may not be so but it is a fact that a great many tonsils which, to the ordinary inspection, seem to be harmless are just the ones which give rise to the most trouble systematically. For example the tubercular tonsil is often exceedingly small and the diagnosis of its diseased condition is made more from the condition of the cervical glands than from anything else. Moreover, by ordinary inspection very little of the tonsil may be seen and yet that tonsil may be much diseased.

In the examination of the tonsil, of first importance is inspection. The tongue should be firmly pressed down so as to view the lower poles. If very little can be seen, the patient may be forced to gag, whereupon the tonsils will be extruded from between the pillars. Of second importance is the palpation for a gland, beneath the angle of the jaw, frequently called the tonsillar gland. As a rule, if it is all palpable, one may conclude that whatever tonsillar tissue is present is responsible for it.

But aside from such examination, the author has found that the palpation of the tonsil is of the greatest value and will give much desired information. If one has a sensitive finger or trains the sensitivity of his fingers to get the required information, he will find that it will help him a great deal in determining the type of tonsil he is dealing with.

Palpation of the tonsil, which includes the palpation of the pillars, has a twofold value; in the first place it may be used to massage the tonsil in order to expel infectious material and secondly it may be used to determine the character of the tonsil itself. One frequently desires to find out whether the tonsil contains pus or serum and at the same time may wish to make a culture of any fluid which is expressed. The tongue is held down firmly with a tongue depressor and, with the index finger of the other hand, firm pressure is made against the anterior pillar and the tonsil and the pillar is massaged

from above downward. Many times, caseous material may be expressed from the crypts in this way and sometimes one can express a thin, glary secretion from the crypts and from the superior tonsillar fossa which, on culture, will show pathogenic organisms.

But the palpation of the entire organ, with the index finger, has not been used as frequently as it should be. We have found it of inestimable value because one can readily tell in this way the size, consistency and area of the tonsil and note how firmly or how loosely it is attached to the surrounding tissues. Sometimes, a gland which cannot be seen, either because it is infolded between the pillars or because it is so deeply buried, can be palpated in this way and found to be of considerable size. The procedure is simple. With the clean index finger, the right finger for the right tonsil, the left for the left, one gently palpates the surface of the gland and behind and in front of it. Enough pressure may be made to note the consistency of the gland. We have frequently encountered tonsils which seemed to be of no significant size which, on palpation were found to be of considerable size, tonsils which were far more pathological than those which are so readily seen in the throat. In one instance, the tonsils were no larger than a hazel nut but it was decided to remove them because of a peculiar feeling to the finger, like fluctuation which afterward was proved to be due to an abscess between the tonsil and the cellular tissues external to it.

2178 Broadway.

The San Francisco Convention Session of the American Medical Association as a Starting Point for Various Tours

The California Convention Headquarters of the American Medical Association, working with the various tourist agencies, civic and commercial organizations, are arranging plans whereby the San Francisco Convention will be the starting point for a number of tours:

One of those will be a three weeks' trip to Honolulu, on a special boat touching at all of the principal ports, including the Leper Colony, and returning to San Francisco.

Another trip under contemplation is up the West Coast of the United States to Alaska and return, allowing returning passengers to leave the boat at Vancouver and travel over the Canadian Pacific East, or at Seattle over the Great Northern Railroad; at Portland and thence East by a number of lines or to San Francisco and Los Angeles or San Diego and back East by any of the numerous lines; or connecting at San Francisco with boats that will return East through the Panama Canal.

Arrangements are also being planned by which persons may begin an entire Oriental tour, starting from the convention a day or so after its close. These trips will include Japan, China, the Philippine Islands and return to San Francisco, or one may go on through the Suez Canal and Europe.

In fact, any and all sorts of combinations of tours to take up as much vacation as one cares to use and to any part of the world will be one of the features easily arranged in connection with the convention.

Persons interested in any of these points or in any other matters connected with their trip to California are requested to write W. E. Musgrave, Chairman of the Local Committee of Arrangements, 806-809 Balboa Building, San Francisco.

Continuity of Treatment in Venereal Diseases.

In his report to the sanitary committee of the City of London for the seven weeks ended February 18th, Dr. W. J. Howarth submits a table which shows that not more than one-third of the patients suffering from syphilis and gonorrhoea completed the course of treatment at the City treatment centre. (*Lancet*, London, March 25, 1922.)

One Cause of Hernia

Meckel's diverticulum may be the sole content of a hernia (Littre's hernia), or it may be present with other portions of the bowel. The diverticulum has been found in umbilical, inguinal, and femoral hernias, strangulated or otherwise.

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The Tall Opponent of Meat

In view of the evidence bearing upon the influence of animal protein in the diet on tallness, as set forth at some length in a recent editorial in this journal, it is paradoxical to observe the activities of some of our tall food experts looking to a reduction in the consumption of meat. The paradox really has an amusing phase. These tall exponents of the new doctrine themselves typify a physique of which we fancy they themselves are properly proud, and at least one of their concepts of biologic superiority, so ingrained in the people of the Nordic race, is based upon this very matter of tallness. The energy of these publicists is itself a heritage inextricably related to the dietetic habits of their ancestors. Those ancestors owed their great stature and prowess in the world very largely to their consumption of fresh meat and fish, a statement easily buttressed by cold facts. We believe that a rational contemplation of these facts ought to send our tall opponents of a liberal meat dietary back to the roast beef and sea food, and induce them to start a crusade looking to the elevation of their short fellows.

In so far as the economic phase of this matter is concerned we hope to see the day when the packers will be superseded by co-operative organizations.

Housework and the Sexual

A great hullabaloo was recently made in France over the dangers residing in athletics for women. At the Olympic Games some French women collapsed after violent exertions, and the whole nation became panicky about the probable effects of the growing interest in athletics upon the potential mothers of the race. Of course, the tragic popula-

tion problem in France makes the people more sensitive to any situation which, like the athletic, raises the question of possible menace to the life of the nation. National conferences of one sort or another have discussed this matter of athletics for women quite thoroughly, and a number of conclusions have been formulated.

But why all this excitement about athletics? One is tempted to grow ironic when one reflects that there has never been any panic over the evil effects of housework with respect to things sexual and procreative. We suspect that the dark-complexioned gentleman in the woodpile is the escape of women from housework into athletics. The field of athletics is one phase of modern emancipation, and the male sex is really manifesting its concern over the said emancipation rather than over the matter of maternity.

When one considers what this same male sex formerly expected of women in the form of drudgery one is frankly amused at its effrontery. The same savants who now appear to be so exercised never thought it odd that the common man, returning to his bed and board at eventide, expected to find a complaisant partner in amorous dalliance in the person of a sadly fagged wife. And as for the morbidity directly unfitting this wife for maternity, what medical publicist ever raised his voice in protest against the sacred old sweatshop known as the home?

The modern man who is reasonably enlightened understands very well that not much can be expected sexually or maternally from a domestically exploited wife, and the whole face of society is changing as a result of this realization.

As between athletics and household drudgery we do not have to make much choice to-day in the interest of a more active sexual life and a better preparedness for maternity, since both are reasonably well regulated. The reasons why the birth rate is not increasing phenomenally have little to do with the physique or sexual capacity of our women. That is another story.

The Why of Miscegenation

In certain parts of our country miscegenation of Whites and Negroes is a constant and large-scale phenomenon. The offending Whites are males.

Now it is a commonplace in the Freudian psychology that the circumstances in which the child learns to love those about him provide the prototype for all future loves, the paradigm into which they must fit; and the attachment of the child to those about him is fundamentally a sex attachment.

Very well, is it not the old institution known as the Mammy, then, who too often stands as the aforesaid prototype? A white man, brought up from birth under such a strong sex influence, will be pretty apt to be unduly attracted to the Negress, as, to his mind, "the dearest and most beautiful woman," standing symbolically for his mother.

The white girl with a Mammy undergoes no such influence, since a child is more strongly attached to a parent of the opposite sex, in the terms of Freud's romance of the family. A young woman tends to be attracted by a man representing symbolically her father.

It appears quite clear that the peculiar relation of the Mammy to her white charge accounts for the prevalence of miscegenation, and explains why it is only the white male who is at fault.

Miscegenation has proved a curious retribution against the enslaving race, viewed morally, but from another standpoint (that of Henry L. Mencken) there are compensations, since it is the best white blood which goes into these "unions," the "Poor Whites" being scorned by the black beauties.

The Revolt of Civilization

Mr. Caspar L. Redfield closes his article on The Revolt of Civilization in the April issue of the MEDICAL TIMES in the following words:

"There is a little paleontological history which goes back some millions of years. That history shows that periods of stress, which correspond to our present unrest activity, were the periods of greatest evolutionary advance, and that calms of the kind Stoddard wishes for were periods in which there was no progress. In more modern times, war-like tribes were the ones which advanced most rapidly in civilization. The loss in killed of the superior individuals was more than compensated for by something else, provided the loss was not great enough to cause the population to become extinct. It was so in Greece and Rome, both of which advanced through incessant warfare, and both of which declined when they became peaceful, and practiced birth control.

"This is not a plea for war, or for the killing of the world's intelligentsia. It is pointing to the fact that activity of the kind which Stoddard deprecates causes more progress in civilization than there is loss by the killing of a few superiors. Civilization will lose nothing by killing off those superiors who will leave no progeny behind them, and Stoddard seems to think that sterile persons are about the only thing that is superior. Civilization is kept alive by those persons who keep the race alive, and Stoddard acknowledges that it is the people now in revolt who are producing the next generation. That revolt is a revolt of civilization and not a revolt *against* civilization. It furnishes that mental and physical activity which lies at the foundation of all progress in civilization. As it goes down to the lowest strata of society, and spreads over the entire world, it presages greater progress in civilization than the world has yet seen."

It seems to us that Mr. Redfield is sustained in his argument by the results to civilization of the "boring from within" of the early Christians. They constituted the most despised element in the Roman State. They were the "Under-Men" of that ancient world. But theirs was a Revolt of Civilization and who will say that the new character which those lowly Roman slaves gave to civilization was a deplorable thing? Just as they kept civilization alive by keeping the race alive, so the Under-Men of to-day are the ones who are keeping it alive. On this point Mr. Redfield makes the following remarks:

"Right here we will raise a question as to the validity of Stoddard's definition of what constitutes superior stock. He seems to think that superior stock is made up of that part of the population which has such a bad attack of brains that it is unable to reproduce, but that is not nature's idea, and it is probable that nature is the highest authority. Any way, she has the final say-so. According to nature, that stock is superior stock which can keep alive through unending generations, and can continue to advance while it is keeping alive. If Stoddard can find any branch of the human family which is dying out because it is not reproducing offspring enough to keep it alive, he may set down that branch as being decadent. Brains are important things, but a person who has his brains developed to the extent that he is lop-sided is not good material, from a racial standpoint."

According to statistics recently published by the Bureau of Social Hygiene, seventy-four per cent of the "superior" types of married women practise birth control.

No doubt the Romans took themselves as seriously as do Stoddard's superiors, but they passed out, and their successors engineered a notable evolution. So it will be again, and again, and again.

How, then, can we be so sure that the hated rebels of to-day will not initiate a greater civilization than we have yet known? The character of civilizations will change, but the human race is a very

potential, not to say an immortal, thing, and in our opinion bound to progress. Why so much perturbation about the death of any civilization? Such is in the nature of things, and it is well; those who are not fit to adjust and survive ought to perish. We do not, by any means, have to be pessimistic as to the destiny of mankind. For our part, we are rather weary of our Stoddardized civilization, which is indeed moribund at this very moment. A new civilization is in seemingly chaotic birth throes. Never fear, the gestation will eventuate in a lusty infant. And the new dispensation will be marked, among other things, by a League, not of Governments, but of Peoples. For institutions of the adored Stoddard type are doomed to yield to the imbecilities of the "superiors" who are making such a mess of things, and to the new economic and social vision, more acute in Europe than in America, and, of course, not possessed anywhere by corrupt and bungling politicians or worshippers of Stoddard's postulate of what a civilization ought to be.

Miscellany

CONDUCTED BY ARTHUR C. JACOBSON, M. D.

Heresy

Nursing and cookery are two subjects that are not exactly exploited in our medical schools. We fancy that a good many recent graduates, and perhaps a good many of the older men, would not know if their patients were being properly cared for, with respect both to nursing and cookery. We believe that cookery might very well be included in the course in chemistry, with "laboratory" practice. Nursing should be taught medical students by nurses connected with the teaching staffs of the nursing schools. In this branch there should also be practical experience.

The critic will say at once that the curriculum is so greatly over-loaded already that it would be impracticable to burden it further. But why is it over-loaded, and why should it be over-loaded? It is over-loaded, apparently, because of the peculiar exactations of the educational over-lords who decree when a college shall be permitted a class-A rating, and who have so arranged things that a professor of obstetrics, for example, cannot teach his students how to take care of a normal case of labor; he has to spend most of his time teaching the boys the technic of operations most of them will never perform.

If a medical school can, through community drives and other means, free itself from the limitations imposed by foundation autocrats, it could very well begin to turn out humanized and useful practitioners. Until this is done there can be no effective answer to the systematic—and idiotic—efforts looking to the crucifixion of the general practitioner and the apotheosis of men trained as though they were going to spend the rest of their lives in a laboratory.

Interesting Items

In a reprint of a paper on psychoanalysis, recently received from a prominent neurologist serving two of the leading clinics in New York City, we note two interesting items.

There is a case report of a clinic patient who suffered from severe pain in his eyes due to an incest complex. It is related that "the patient had purchased several pair of expensive binoculars, and had fitted himself with glasses though not needing them."

Once in a while the luxurious clinic habitué is given away unwittingly by the clinician, as in the instance just cited. The title of the paper should have been: *Psychoanalysis as an Aid in the Detection of Able-to-pay Clinic Patients.*

The other item appears in a case report in which the following lines occur: "Soon after her father's disappearance, her mother sold the farm, moved to a nearby city and practiced Christian Science nursing."

This set us to wondering as to the art of Christian Science nursing. We presume that the Christian Science nurse does not have to attend her client at the bedside. Doubtless it is sufficient in caring for one suffering from an error commonly known as typhoid fever to sit comfortably at one's own fireside and scotch the victim's error while he purges and raves.

What a lot of unnecessary trouble our regular nurses do give themselves!

(Concluded from page 112)

Operation. November 1, 1914. Exploration through a right rectus incision showed that the bullet had not penetrated the abdominal cavity. Guttapercha tissue drains inserted into wounds of exit and entrance.

November 3—Guttapercha tissue drains removed from bullet wounds. No signs of infection present. November 7—Wound dressed, sutures removed. Wound healed by primary union, no redness, tenderness or swelling.

Further Comments

Intraperitoneal damage is to be determined by inspection, experience, signs and symptoms. Perforation of hollow viscera of themselves present no symptoms; the guiding signs are those of hemorrhage and peritonitis. Shock, rapid pulse, or rigidity may not exist at first. Determination of intra-abdominal injury may be doubly difficult in cases which present no wound of exit. In cases of doubt it is best to open the abdomen timely if unnecessarily rather than to lose an opportune golden chance to save the patient's life.

In the civil case mentioned, it was too early for the development of marked signs of hemorrhage or peritonitis. There was no temperature above normal limits and the pulse rate was but slightly accelerated. The leukocyte count and flexion of the left thigh and knee however indicated nature's attempt to express trouble.

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- 4—Wounds of the Abdominal Viscera, W. W. Wagstaffe, O.B.E., A. Major, R.A.M.C. (S.R.) in *Official History of the Great War. Medical Services. Surgery of the War.* Vol. I p. 474. His Majesty's Stationery Office, 1922.

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moved during the test which accounts for the large amount of 200 c. cs. The indigo carmine test was next carried out also intravenously with 0.16 grammes of the dye dissolved in about 20 c. cs. of warm sterile water. In two or three minutes the right side discharged through the catheter a positive and rapidly increasing blue color, which corresponded with the time of appearance of the phenosulphonephthalein. A digression may be permitted, to say that the writer has found the latter little detail very serviceable in determining the time of appearance of the latter dye. Instead of adding the sodium hydrate or other alkali to the specimen bottle which changes the specific gravity and other characteristics on analysis, he spreads the alkali on a piece of blotting or filter paper and drops the urine upon this every few seconds. Contrast with the white background

of the paper permits the demonstration of very small quantities of the coloring matter. From the left side no indigo carmine at all was delivered in a little over ten minutes. Radiography was negative for stone in kidney or ureter, and positive only for enlargement. Operation was performed August 27, 1914, by Dr. Benjamin T. Tilton at St. Mark's Hospital with the writer associated with him. The patient was originally referred to him in private and by him to the author for urologic diagnosis. Under ethyl chlorid and ether anesthesia in the right lateral renal position, a long incision was made in the left loin from near the spine just below the left twelfth rib downward and forward to the anterior superior spine of the illum through the superficial field of muscles and perirenal fat down to the capsule. The kidney was found to be greatly enlarged, easily separable throughout its extent except at its upper pole which was rather firmly fixed through a superficial abscess, which was slightly opened in breaking through the adhesions, but prevented from leakage by gauze sponges. Full delivery was impossible without the resection of the twelfth rib for an inch and a half. The pelvis and ureter were isolated, tied as low down in the wound as accessible and then divided and both stumps cauterized with carbolic acid and alcohol. The proximal stump was used as a guide to the pedicle which was clamped, divided close to the kidney after turning the pelvis forward, ligated in halves and then in its individual blood vessels and dropped back into the wound. Thorough cleansing, free drainage at both angles of the upper and lower pockets and layer suture of the wound followed. The patient was returned to bed in very fair condition. Moderate stimulation during the operation had been necessary. The temperature ranged from 102° during the first 24 hours, to 104° during the next two days and finally declined to practically normal on the fifteenth day after operation with the pulse in correspondence. The right kidney began its function immediately without abeyance. Eleven ounces were passed during the first six hours, which practically duplicated the findings from the specimen in the right side prior to the operation. In the first 24 hours 38½ oz. of urine were passed and 69 oz. during the second 24 hours, 97 oz. during the third, 60 oz. during the fourth with some loss of urine in the stools, 92 on the fifth and then 34 oz. on the sixth day, and about the same quantity thereafter. The postoperative care was such standard methods as protoclysis and mild stimulation until the kidney and condition of the patient had improved. The usual surgical care of such a wound was followed and the patient was discharged on the 29th day for a rest in the country.

The pathological specimen contained 2 ounces of foul *bacillus coli communis* pus, and detritus, but neither gravel nor stones, and showed the kidney substance totally destroyed as an organ. Numerous adhesions covered the surface of the kidney and pelvis and made mobilization rather difficult.

The condition of the patient for a long time remained that of well being. He was absent from town and thus missed cystoscopy, soon after complete recovery. This prevented the addition of its findings to these notes. Such investigations should, in my opinion and experience, be repeated at stated intervals for several years before the patient is safe.

Final notes: This patient totally disappeared for nearly seven years. In the latter part of 1921 his wife summoned me to his bedside saying that he had maintained very good health up to about 1920 when he began to fail. The chief complaints were weakness, emaciation, inability to work, paleness and swelling of the feet.

This edema came at first in attacks but had finally remained constant and progressive.

On examination I found the man in the last stages of uremia. He was conscious, able to describe the course of his disease just as his wife had outlined it to be but admitted that he knew his end could not be very far off. Analysis of his urine showed that the remaining kidney had also been worn to pieces by the same infection proceeding from the same source namely intestinal toxemia. I was called out of town and during a very brief absence he died in an attack of uremia under the charge of one of my hospital staff. The kidney was not obtained because my assistant was sure that a private family would refuse it. Later when the wife came in to see me she stated that she would willingly have permitted removal of the kidney. Thus one's best intuition as to how to deal with private patients is not always correct and the opportunity of possessing a very fine specimen of kidney destruction was lost.

The case indicates very clearly, what is too little realized and practiced, namely that all severe surgical urinary disease requires prolonged aftercare exactly like syphilis or tuberculosis and the various forms of medical nephritis.

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There were no other symptoms. The general state of health was excellent. He was treated for chronic cystitis, pyuria, with bladder irrigations, instillations, sounds and prostatic massages for fully five years on and off. As his duty required constant moving about from one city to another, he has consulted numerous physicians in all parts of the country for relief of his condition. His urine has been examined hundreds of times, and in each instant the laboratory report was laconic: Pus, no gonococci.

On examination, patient was well developed and nourished. The external genitals apparently normal. The prostate gland and seminal vesicles normal and their respective secretions contained no pus and no gonococci. The catheterized bladder urine was hazy, acid in reaction, contained a trace of albumin and numerous pus cells. The urethoscopic and cystoscopic findings were as follows: The verumontanum normal in size, not congested, and studded by a few pin point elevations. At its anterior extremity a broad commissure was seen connecting it with the right lateral wall of the posterior urethra. At the anterior border of this commissure a deep, crater-like excavation, apparently an old healed (tuberculous?) ulcer, was observed. The left ureteral orifice was pouting and intensely inflamed. The ureteral catheters entered both renal pelvis without any obstruction. The urine obtained from the right kidney was negative. The left urine was cloudy, shreddy, and on microscopic examination contained numerous pus cells and many tubercle bacilli. The phenolphthalein was of normal time and good concentration on both sides.

While it may be true that gonococci are seldom found in cases of chronic gonorrhreal infection, it is equally as true that their absence should be the reason for carrying the investigation a little further. Even then it is extremely rare to find a gonorrhreal infection of the bladder, acute or chronic, because of the absence of glandular structure, the favorite hiding place of gonococci, in the vesical mucosa.

When it is remembered that pyuria is a symptom, and not a disease, and that it may be due to a focus of infection anywhere from the meatus to the renal parenchyma, and that persistent presence of pus in the catheterized bladder urine of a young male, with or without the history of gonorrhea, usually indicates trouble in the upper urinary tract—less errors in the urological diagnosis would be made.

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malis. (Fig. 7). The mucosa and periosteum within this incision are elevated and removed.

(c) A mucoperiosteal flap is then made as in the frontal sinus operation. Here Dr. Halle makes only the second and third incisions, the third incision being omitted. The flap is elevated and reflected downward. (Fig. 8).

(d) A quadrelateral window of bone is chiseled in the nasal bone, leaving a border about an eighth of an inch all around this window. Great care must be exercised here not to perforate through the skin. (Fig. 9).

(e) A probe is introduced through the canaliculus into the lacrimal sac and the nasal side of it grasped with a fine tear-sac ceasing forceps and the entire nasal side excised with a knife. (Fig. 9).

(f) The mucoperiosteal flap is then replaced and held in position by a small piece of iodoform gauze packing. (Fig. 10).

The post operative treatment consists in the removal of the packing in 24 to 48 hours, and daily nasal douchings to clear out accumulated secretions.

211 Henry Street.

The Physician's Library

Diseases of the Skin. By Henry W. Stellwagen, M.D., Professor of Dermatology in Jefferson Medical College. 9th edition; 1,300 pages, and over 350 illustrations. Philadelphia and London: W. B. Saunders Co., 1922.

It is a good deal like carrying coals to Newcastle when one attempts to review this long-established and highly valued book. Suffice it to say that Dr. Stellwagen has presented in his latest edition everything new in dermatology and has rejected those ideas which are not now accepted by the followers of his particular branch of medicine. This volume, as of yore, offers to the general practitioner as well as to the specialist, everything in the dermatological field and it is presented in a style which is pleasing to follow. The typographical work and the pictures leave little to be desired.

Dyke's Automobile and Gasoline Engine Encyclopedia. Cloth, flexible cover; 13th edition. Chicago: Goodheart-Willcox & Co., 2009 S. Michigan Ave., 1923.

The newest edition of this very useful encyclopedia, which has been entirely rest and re-edited, comes at an opportune time. Every motorist who is at all interested in the care of his car, would do well to purchase this book. It explains all the principles of the parts involved in motor car construction and it shows in detail how the motorist can test, adjust, repair or time the various parts of his car and how he can find trouble.

Such matters as ignition, carburetion and the subject of valve systems are very thoroughly covered. By means of an elaborate index, the motorist can turn to any subject and find that it is most completely covered. A volume like this is likely to prove a life-saver to the owner of a car who is not skilled in the care thereof.

Diseases of the Ear, Nose and Throat. By Wendell C. Phillips, M.D., New York Post-Graduate Hospital. 6th edition; 881 pages. Philadelphia: F. A. Davis Co., 1922.

This edition carries out the excellence of the previous volumes, together with the addition of more material. For example, there has been a general revision in a number of the sections. Fifty new cuts have been added and the book has been brought entirely up to date.

This volume has gained wide-spread popularity as is attested by the fact that since 1911 it has gone through six editions, and the hope is expressed that it may meet with as much favor in the next twelve years as it has in the past twelve.

Anatomy and Physiology. By Elizabeth R. Bundy, M.D., assisted by Dr. Martha Tracy and Miss Grace Watson. 442 pages. Philadelphia: P. Blakiston's Son & Co., 1923.

This book is intended for nurses and for institutions where an elementary knowledge of these important subjects is desired. It suits the purpose to perfection and can be recommended to anyone who desires to get a bird's-eye view of anatomy and physiology.